

FOR STATE  
HEALTH DEPT.

15919

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15921

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>		c. LENGTH OF STAY IN Tb <b>1hr</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		e. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>	
3. NAME OF DECEASED (Type or print) <b>Pearl Cashman</b>		4. DATE OF DEATH Month <b>11</b> Day <b>8</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. BIRTH DATE OF BIRTH <b>1/18/21</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Statistical Clerk</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Gov</b>	
11. BIRTHPLACE (State or foreign country) <b>Vt.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George M. Cashman</b>		14. MOTHER'S MAIDEN NAME <b>Cora Jaynes</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>009-10-0589</b>	
17. INFORMANT <b>Husband</b>		18. ADDRESS <b>12905 Holdridge Rd., S. S. Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cardiorespiratory failure due to</b> DUE TO (b) <b>overdose of Placidyl</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Deceased took overdose of Placidyl</b>	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>1:00</b> <b>11</b> <b>8</b> <b>1966</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>	20f. (City or town) (County) (State) <b>Silver Spring Montg. Md.</b>
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Peap</b> M.D.		22. DATE SIGNED <b>Nov. 8, 1966</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. PEAP, M.D.</b>		23. LOCATION (City or Town) (County) (State) <b>Silver Spring, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>Nov. 12, 1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven Cemetery</b>	
24. FUNERAL DIRECTOR <b>Clark E. Wisor</b>		25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>434 Georgia Ave. Silver Spring, Md.</b>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1931

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January

January

February

February

March

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April

April

May

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June

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June

July

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November

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November

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December

December

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15920

CERTIFICATE OF DEATH

15922

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (Rural)</b>		c. LENGTH OF STAY IN lb <b>12 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington</b>		d. STREET ADDRESS <b>3503 Northampton St., N.W.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Mary</b> Middle <b>Roe</b> Last <b>NEELY</b>		4. DATE OF DEATH Month <b>November</b> Day <b>24</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>Oct. 8, 1911</b>
9. AGE (In years last birthday) yrs. <b>55</b>		IF UNDER 1 YEAR Months <b>24</b> Days <b>19</b> Hours <b>66</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Akron, Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mark W. Roe, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Elizabeth Daugherty</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>577-10-5625</b>	
17. INFORMANT <b>St., N.W. Washington, D. C.</b>		18. <b>Capt. William E. Neely, USN, 3503 Northamp-</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of the breast with widespread metastases</b> <b>170X</b> DUE TO (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 12</b> , 1966, to <b>Nov. 24</b> , 1966, that (I) (we) last saw the deceased alive on <b>Nov. 24</b> , 1966, and that death occurred at <b>1035AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Halbert E. Ashworth</b>		22b. DATE SIGNED <b>Nov. 25, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Halbert E. Ashworth</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/28/66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. ADDRESS <b>5130 Wisconsin Ave., N.W. Washington, D. C.</b>	

12032

12030

Director of Bureau

Director of Bureau

Washington

12 days

Records (Bureau)

Level assigned

1901 Washington St.

1901

1901

1901

Oct. 7, 1901

1901

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND										
15921					15923					
1. PLACE OF DEATH					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)					
a. COUNTY <b>Montgomery</b>			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		a. STATE <b>Maryland</b>			b. COUNTY <b>Montgomery</b>		
c. LENGTH OF STAY IN 1b <b>MARYLAND</b>			d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Rockville</b>			d. STREET ADDRESS <b>301 Mount Vernon Place</b>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
3. NAME OF DECEASED (Type or print)					4. DATE OF DEATH					
First Middle Last <b>Baby Boy Neiderhouse</b>					Month Day Year <b>November 8, 19 66</b>					
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDDED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>11/7/66</b>		9. AGE (In years last birthday) yrs. Months Days <b>21</b>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>			12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME					14. MOTHER'S MAIDEN NAME <b>Vicki S. Neiderhouse</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Chart</b>			Address		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Immature birth (340 gms) neonatal death</b> 776 X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c)									INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)									19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that death occurred at _____ M, from the causes and on the date stated above.										
22a. SIGNATURE <i>Salvatore Battiatto</i> 22c. PHYSICIAN'S NAME (Type) <b>Salvatore Battiatto, M.D.</b>					22b. DATE SIGNED <b>11/8/66</b>			22d. ADDRESS <b>1000 Lebanon Street, Silver Spring, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE THEREOF <b>11/15/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Gate of Heaven</b>			23d. LOCATION (City, town or county) (State) <b>Silver Spring, Md.</b>		
24. FUNERAL DIRECTOR <b>Tyson Wheeler Funeral Home</b>					24b. ADDRESS <b>Rock. Pike</b>		25a. REC'D BY REGISTRAR <b>NOV 16 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

6-192904

15083

11083

Montgomery

Montgomery

Montgomery

Rockville

Silver Spring

301 Mount Vernon Place

Holy Cross Hospital

60

November 8,

Heterophone

Baby Boy

27

11/7/66

White

Male

Montgomery

Victor E. Keldarhouse

Chart

Immature male (2nd year) genital death

11/1/66

1000 Lebanon Street, Silver Spring, Md.

Salvatore Battista, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15922 CERTIFICATE OF DEATH 15924											
1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> <u>Wheaton Maryland.</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton.</u> c. LENGTH OF STAY IN 1b <u>2 yrs</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>90 Kensington Garden Nursing Home.</u>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery.</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u> d. STREET ADDRESS <u>3000 Mc Conas Ave, Wheaton.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>						
3. NAME OF DECEASED (Type or print) <u>Jones F Noel.</u>			First Middle Last		4. DATE OF DEATH <u>11/13/66</u>		Month Day Year <u>11</u> <u>13</u> <u>19</u>				
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9/26/1892</u>		9. AGE (In years last birthday) <u>74</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Electrical Engineer</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Gov't</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Wash D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				
13. FATHER'S NAME <u>Austin Seay Noel</u>					14. MOTHER'S MAIDEN NAME <u>Fannie Seay.</u>						
15. WAS DECEASED EVER IN U.S. ARMY FORCES? (Yes, no, or unknown)			16. SOCIAL SECURITY NO. <u>Yes</u>		17. INFORMANT <u>Mrs Ethel N Cahill</u>		Address <u>4501 45th St N.W. D.C.</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>arteriosclerotic c-v disease</u> DUE TO (c) <u>generalized arteriosclerosis</u>										INTERVAL BETWEEN ONSET AND DEATH <u>1 wk</u> <u>10 yrs</u> <u>20 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)								
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>11</u> <u>13</u> <u>1966</u>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)				
21. I certify that I (this hospital) attended the deceased from <u>January, 1966</u> , to <u>Nov 13, 1966</u> , that I (we) last saw the deceased alive on <u>11/13</u> 1966, and that death occurred at <u>1 P</u> -M, from the causes and on the date stated above.											
22a. SIGNATURE <u>H.F. Kreuzburg</u>					M.O. ATTENDING PHYS. <input checked="" type="checkbox"/> MEO. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/13/66</u>				
22c. PHYSICIAN'S NAME (Type) <u>H.F. Kreuzburg</u>					22d. ADDRESS <u>2852 16th St NW Wash DC</u>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>11/16/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Washington, D.C.</u>				
24. FUNERAL DIRECTOR <u>W.R. Murtmann &amp; Son Funeral Home.</u>					25a. REC'D BY REGISTRAR DATE <u>NOV 16 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

1953

1953



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 21 Film G383 12/12/66 mh

Item #8 Film #G303 12/13/66 pc

15923

## CERTIFICATE OF DEATH

15925

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>				c. LENGTH OF STAY IN 1b <u>9 days/4 hrs/25 min</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				15.1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium Hospital</u>				d. STREET ADDRESS <u>10205 Kenney Ave.</u>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Rose</u> Last <u>O'Donnell</u>				4. DATE OF DEATH Month <u>November</u> Day <u>27</u> Year <u>1966</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>June August 4, 1896</u>	
9. AGE (In years last birthday) <u>70</u>		IF UNDER 1 YEAR Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>		IF UNDER 24 HRS. Months <u>70</u> Days <u>70</u> Hours <u>70</u> Min. <u>70</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Hswt</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>---</u>		11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>Wm. Tebbs</u>				14. MOTHER'S MAIDEN NAME <u>Martina Donaldson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>579-38-9485</u>			
17. INFORMANT Address <u>Hospital Records - 7600 Carroll Ave.</u>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis massive</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chr Myocardial Disease Hypertension</u> DUE TO (c) <u>Diabetes mellitus</u>				INTERVAL BETWEEN ONSET AND DEATH <u>11/10/66</u> <u>1959</u> <u>1960</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1b.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)	
20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <u>July 5, 1945</u> , to <u>11/27/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/27/1966</u> , and that death occurred at <u>2:00 AM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Howard T. Morse</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/27/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Howard T. Morse</u>				22d. ADDRESS <u>103 Carroll Ave Takoma Park Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-30-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Gate of Heaven Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Silver Spring, Md.</u>	
24. FUNERAL DIRECTOR ADDRESS <u>Joseph Gaudin's Sons Washington, D.C.</u>				25a. REC'D BY REGISTRAR DATE <u>DEC 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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THE UNIVERSITY OF CHICAGO  
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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT

15924

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15926

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN TB <b>32 min.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital (Bethesda)</b>				d. STREET ADDRESS <b>2616 East West Highway</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>Charles</b> Middle <b>Abraham</b> Last <b>PARK</b>				4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>19 66</b>				
5. SEX <b>Male</b>		6. COLOR OR RACE <b>Cauc</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		B. DATE OF BIRTH <b>Nov. 30, 1882</b>		
9. AGE (In years last birthday) yrs. <b>83</b>		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/>		IF UNDER 24 HRS. Hours <input type="checkbox"/> Min. <input type="checkbox"/>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Civil Engineering</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>- - -</b>		11. BIRTHPLACE (State or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Park</b>				14. MOTHER'S MAIDEN NAME <b>Luella Jordon</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>267 50 9363</b>		17. INFORMANT <b>Bethesda,</b> Address <b>Maryland</b> <b>Mrs. Maude L. Park, 2616 East West Highway</b>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary insufficiency, acute</b> DUE TO (b) <b>Cardiovascular disease</b> DUE TO (c) <b>years</b>							INTERVAL BETWEEN ONSET AND DEATH <b>1 hour</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <input type="checkbox"/> p.m. <input type="checkbox"/> 19 <input type="checkbox"/>			20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>								
ACTUAL SIGNATURE <b>John G. Ball</b> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <b>John G. Ball, M.D.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>11/9/66</b>				
				Address (Street, city, town, or county)				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
<b>Burial</b>		<b>11-12-1966</b>		<b>Arlington National</b>		<b>Arlington, Virginia</b>		
24. FUNERAL DIRECTOR <b>Joseph Gawler Funeral Home</b>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
<b>5130 Wisconsin Ave., N.W. Washington, D.C.</b>				<b>NOV 18 1966</b>		<b>Charles Judge</b>		



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Marriage

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John C. Smith, M.D.

John C. Smith, M.D.

John C. Smith, M.D.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15925 CERTIFICATE OF DEATH 15927

1. PLACE OF DEATH a. COUNTY Montgomery		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland		b. COUNTY Montgomery	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) Rockville		c. LENGTH OF STAY IN ID		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rockville	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) 17100 Overhill Road		d. STREET ADDRESS 17100 Overhill Rd.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First EARL		Middle W.		Last PARKER	
5. SEX Male		6. COLOR OR RACE White		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH 7/13/96		9. AGE (In years last birthday) 70 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Ret.		10b. KIND OF BUSINESS OR INDUSTRY Steel		11. BIRTHPLACE (County & State, or foreign country) Texas	
12. CITIZEN OF WHAT COUNTRY? USA		13. FATHER'S NAME John W. Parker		14. MOTHER'S MAIDEN NAME Sarah C. Haney	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No		16. SOCIAL SECURITY NO. 408-07-6073		17. INFORMANT Alma M. Parker- Item# 2	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) CORONARY THROMBOSIS 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) CORONARY ARTERY DISEASE DUE TO (c) ACUTE VENTRICULAR ARRHYTHMIA		INTERVAL BETWEEN ONSET AND DEATH 3 HOURS 15-20 YRS. 30-MINUTES		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) CHRONIC PULMONARY EMPHYSEMA		20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)		21. I certify that (I) <del>this hospital</del> attended the deceased from Nov. 1, 1966, to Nov. 2, 1966, that (I) <del>was</del> last saw the deceased alive on Nov. 1, 1966, and that death occurred at 5:50 A.M. from the causes and on the date stated above.		22a. SIGNATURE Gordon S. Rosenberger M.D.	
22b. DATE SIGNED 11/1/66		22c. PHYSICIAN'S NAME (Type) Gordon S. Rosenberger		22d. ADDRESS 310 W. Montg. Ave., Rockville, Md.	
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial-Transit		23b. DATE THEREOF 11/2/66		23c. NAME OF CEMETERY OR CREMATORY Woodlawn Memorial Park	
23d. LOCATION (City, town or county) (State) Nashville, Tenn.		24. FUNERAL DIRECTOR Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.		25a. REC'D BY REGISTRAR DATE NOV 3 1966	
25b. REGISTRAR'S SIGNATURE J. Charles Judge					

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15926

15936

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>				c. LENGTH OF STAY IN 1b <u>DOA</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>313 Lincoln Ave</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Spencer</u> Middle <u>Prather</u> Last <u>Prather</u>				4. DATE OF DEATH Month <u>11</u> Day <u>21</u> Year <u>1966</u>			
5. SEX <u>M</u>		6. COLOR OR RACE <u>Ngr.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		8. DATE OF BIRTH <u>July 27 1903</u>	
9. AGE (In years last birthday) <u>63</u> yrs		IF UNDER 1 YEAR Months <u>11</u> Days <u>21</u> Hours <u>19</u> Min.		IF UNDER 24 HRS. Hours <u>19</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>				13. FATHER'S NAME <u>Henry Prather</u>			
14. MOTHER'S MAIDEN NAME <u>Evelyn Martin</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			
16. SOCIAL SECURITY NO.				17. INFORMANT <u>Delores Crutchfield - same as #2</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5811 fatty metamorphosis liver, severe</u> DUE TO (b) <u>Chronic alcoholism</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)			
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE <u>John B. Bell</u> M.D.				22. DATE SIGNED <u>11/22/66</u>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>11/25/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville Montg. Mld.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Suowden</u> ADDRESS <u>Rockville, Md.</u>				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>NOV 28 1966</u>							

15335

15335

Official Examination & Certification of

100

*[Faint, illegible text and markings covering the majority of the page, likely bleed-through from the reverse side.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15927

CERTIFICATE OF DEATH

15928

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA, MARYLAND</b>		c. LENGTH OF STAY IN 1b <b>15.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>RESMOR SANITARIUM &amp; HOSPITAL</b>		d. STREET ADDRESS <b>7102 Exfair Road</b>	
3. NAME OF DECEASED (Type or print) <b>James Rea Pattison</b>		4. DATE OF DEATH <b>November 3 1966</b>	
5. SEX <b>MALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>26 Jan. 1890</b>
9. AGE (In years lost birthday) <b>76</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Patent Attorney</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Meade Kansas</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>William Rea Pattison</b>		14. MOTHER'S MAIDEN NAME <b>Nellie Stivers</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>YES WW I</b>		16. SOCIAL SECURITY NO. <b>577-09-7775</b>	
17. INFORMANT Address <b>Mary Alice Pattison - See Item #2</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebrovascular accident</b> DUE TO (b) <b>Cerebral arteriosclerosis.</b> DUE TO (c) <b>331X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>?</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 3, 1966</b> to <b>Nov 3, 1966</b> that (I) (we) lost saw the deceased alive on <b>Nov 3, 1966</b> and that death occurred at <b>300 P</b> M, from causes on and on the date stated above.		22a. SIGNATURE <b>George A. Gray Jr.</b> M.D. ATTENDING PHYS. MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	
22c. PHYSICIAN'S NAME (Type) <b>GEORGE A. GRAY JR.</b>		22d. ADDRESS <b>4140 Chevy Chase Drive, Chevy Chase, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-8-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Nat'l. Cem. Arlington, Va.</b>	23d. LOCATION (City or Town) (County) (State)
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc.</b>		25. REC'D BY REGISTRAR <b>Charles Judge</b>	
26. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 14 1966</b>	

2521



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

## CERTIFICATE OF DEATH

15928

15929

<b>1. PLACE OF DEATH</b> a. COUNTY <b>Montgomery</b> <span style="float: right;"><b>MARYLAND</b></span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Gakthersburg</b> c. LENGTH OF STAY IN lb <b>2 yrs. 5mo</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>Asbury Methodist Home</b>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Hamilton</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hamilton</b> d. STREET ADDRESS <b>83-3</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First <b>Annie</b> Middle <b>Tavener</b> Last <b>Peugh</b>			<b>4. DATE OF DEATH</b> Month <b>November</b> Day <b>6</b> Year <b>19 66.</b>				
<b>5. SEX</b> <b>Female</b>		<b>6. COLOR OR RACE</b> <b>White</b>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			
<b>8. DATE OF BIRTH</b> <b>July 14 1884</b>		<b>9. AGE</b> (In years last birthday) <b>82 yrs.</b>		<b>10. IF UNDER 1 YEAR</b> Months <b>4</b> Days <b>4</b>			
<b>11. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <b>House keeper</b>		<b>12. KIND OF BUSINESS OR INDUSTRY</b>		<b>13. BIRTHPLACE</b> (County & State, or foreign country) <b>Hamilton, Virginia</b>			
<b>14. CITIZEN OF WHAT COUNTRY?</b> <b>U.S.A.</b>		<b>15. FATHER'S NAME</b> <b>James Braden Peugh</b>					
<b>16. MOTHER'S MAIDEN NAME</b> <b>Ella Tavener</b>		<b>17. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) <b>231-62-1884A</b>					
<b>18. SOCIAL SECURITY NO.</b>		<b>19. INFORMANT</b> Address <b>Asbury Home Records.</b>					
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4301</b> <b>Acute coronary thrombosis</b> DUE TO (b) <b>Generalized arteriosclerosis</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> <b>CAUSE OF DEATH</b> (IF EITHER, NOTIFY MEDICAL EXAMINER)							
<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)							
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. <b>19</b> p.m.		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)			
<b>20f. (City or town)</b>		<b>20g. (County)</b>		<b>20h. (State)</b>			
<b>21. I certify that (I) (this hospital) attended the deceased from</b> <b>7/14/64</b> <b>19</b> , to <b>11/6/66</b> <b>19</b> , that (I) (we) last saw the deceased alive on <b>11/6/66</b> <b>19</b> , and that death occurred at <b>5 P.M.</b> from the causes and on the date stated above.							
<b>22a. SIGNATURE</b> <b>Henry C. Scruggs, M. D.</b>							
<b>22b. PHYSICIAN'S NAME</b> (Type) <b>Henry C. Scruggs, M. D.</b>							
<b>22c. ADDRESS</b> <b>Asbury Home Records.</b>							
<b>22d. DATE SIGNED</b> <b>11/6/66</b>							
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <b>Burial</b>		<b>23b. DATE THEREOF</b> <b>11-9-66</b>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <b>Lake View</b>			
<b>23d. LOCATION</b> (City, town or county) <b>Hamilton</b>		<b>23e. (State)</b> <b>Virginia</b>		<b>23f. REC'D BY REGISTRAR</b> <b>Charles Judge</b>			
<b>24. FUNERAL DIRECTOR'S SIGNATURE</b> <b>Ernest C. Gartner</b>							
<b>25. REGISTRAR'S SIGNATURE</b> <b>Charles Judge</b>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15320

Virginia

Hamilton

2 yrs. ago

Montgomery

Glennsboro

Army Medical Corps

November 6

Lebanon

Lebanon

Lebanon

July 14 1934

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Lebanon

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Hamilton, Virginia

Lebanon

James H. H. H.

191-10-1034

Henry H. H. H.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15930

FOR STATE HEALTH DEPT.

15929

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Pages 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <b>Maryland</b> Balto. <del>Montgomery</del> b. COUNTY <del>Montgomery</del> <b>Catonsville</b> 03-2	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring,</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <del>Silver Spring</del> <b>Catonsville</b>	
c. LENGTH OF STAY in lb <b>1hr</b>		d. STREET ADDRESS <b>101 N. Rolling Rd.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Ethel M Piet</b>		4. DATE OF DEATH Month <b>11</b> Day <b>9</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/26/05</b>
9. AGE (In years lost birthday) <b>60</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>None</b>	
10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>Baltimore, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		13. FATHER'S NAME <b>Edward J. <del>Stephenson</del> Stephens</b>	
14. MOTHER'S MAIDEN NAME <b>Ann Mae Berryman</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT <b>Husband</b> Address <b>Same</b> <b>Harry Piet</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> DUE TO (b) <b>Essential Hypertension</b> DUE TO (c) <b>4201</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>Belden R. Reap</b> M.D.		22. DATE SIGNED <b>Nov. 9, 1966</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. REAP, M.D.</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-12-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Md.</b>
24. FUNERAL DIRECTOR <b>Witzke Funeral Directors</b>		25a. REC'D BY REGISTRAR <b>Nov 14 1966</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>

03051

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15930

## CERTIFICATE OF DEATH

15931

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> c. LENGTH OF STAY IN TB  d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>PRINCE GEORGES</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hyattsville</u> 16-2 d. STREET ADDRESS <u>6218 42nd AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) <u>Minta B Pittman</u>			<b>4. DATE OF DEATH</b> Month <u>NOVEMBER</u> Day <u>20</u> Year <u>1966</u>				
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>CAU.</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>B. DATE OF BIRTH</b> <u>7/20/82</u>	<b>9. AGE</b> (In years last birthday) <u>84</u> yrs. IF UNDER 1 YEAR: Months <u>0</u> Days <u>0</u> IF UNDER 24 HRS: Hours <u>0</u> Min. <u>0</u>	<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own Home</u>		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>North Carolina</u>			
<b>13. FATHER'S NAME</b> <u>Robert T Bonner</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Rebecca Tripp</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b>  		<b>17. INFORMANT</b> Address <u>Columbus W.E. Pittman Same as #2</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>SHOCK</u> DUE TO <u>4201</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: (b) <u>MYOCARDIAL INFARCTION-PROGRESSIVE</u> DUE TO <u>2 DAYS</u> (c) <u>CORONARY ARTERIOSCLEROSIS</u> <u>15 YEARS</u>					INTERVAL BETWEEN ONSET AND DEATH <u>15-40-PS</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
<b>20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH</b> (If either, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/>		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)  					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour o.m. <u>19</u> p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While of work <input type="checkbox"/> Not While of work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)  	<b>20f. (City or town)</b> (County) (State)  	<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>1956</u> , to <u>20 NOV. 1966</u> , that (I) (we) last saw the deceased alive on <u>19 NOV 1966</u> , and that death occurred at <u>4:00 A.M.</u> from causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Henry R. Wolfe</u>			<b>22b. DATE SIGNED</b> <u>11/20/66</u>		<b>22c. PHYSICIAN'S NAME (Type)</b> <u>Henry R. Wolfe</u>		
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>			<b>23b. DATE THEREOF</b> <u>11/22/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Ft Lincoln</u>		
<b>23d. LOCATION (City or Town)</b> (County) (State) <u>Colman Manor P.G. Md.</u>			<b>24. FUNERAL DIRECTOR</b> ADDRESS <u>Francis Masch's Sons Hyattsville, Md.</u>				
<b>25a. REC'D BY REGISTRAR</b> <u>NOV 21 1966</u>			<b>25b. REGISTRAR'S SIGNATURE</b> <u>J. Charles Judge</u>				

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15530

STATEMENT OF THE

15531

IN WITNESS WHEREOF, I have hereunto set my hand and the seal of the said Court, at the City of New York, this 15th day of June, 1964.

BY THE COURT:  
JULIUS ROSENTHAL, Clerk of the Court



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15931

## CERTIFICATE OF DEATH

15932

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN lb <u>2 days</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>6901 Marbury Rd</u>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>DORA</u> <u>PORTEN</u>		4. DATE OF DEATH Month Day Year <u>NOV</u> <u>17</u> <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1870</u> <u>96</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Russia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Yehoshua Gerber</u>		14. MOTHER'S MAIDEN NAME <u>Toby --</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Son</u> <u>David S. Porten</u> Address <u>8315 Brook Lane Bethesda, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral vascular accident</u> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerosis - Hypertension</u> DUE TO (c) <u>Myocardial necrosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>11/15/66 11/17/66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>15 November 1966</u> , to <u>17 November 1966</u> , that (I) ( <u>we</u> ) last saw the deceased alive on <u>17 November 1966</u> , and that death occurred at <u>4:40p</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>[Signature]</u>		22b. DATE SIGNED <u>11/17/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>A BLAJWA'S</u>		22d. ADDRESS <u>3900 16th Street, N. W.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/18/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>B'nai Israel Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Oxon Hill, Maryland</u>
24. FUNERAL DIRECTOR <u>Bernard Danzansky &amp; Sons N.W., Wash.D.C.</u>		25a. REC'D BY REGISTRAR <u>NOV 21 1966</u>	25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



12335

DEPARTMENT OF STATE

12331

RECEIVED  
12 OCT 1964  
U.S. DEPT. OF STATE  
WASHINGTON, D.C.

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15932

15933

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>TAKOMA PARK</u>		c. LENGTH OF STAY IN 1b <u>110 hrs. 25 min.</u> <u>TAKOMA PARK</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium &amp; Hospital</u>		d. STREET ADDRESS <u>8311 ROANOKE AVE. - Apt. 1</u>	
3. NAME OF DECEASED (Type or print) First <u>Ruth</u> Middle <u>ELINORE</u> Last <u>Post</u>		4. DATE OF DEATH <u>NOVEMBER 4</u> 19 <u>66</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>6</u> / <u>1917</u> <u>49</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSEWIFE - MEAT WRAPPER - SAFEWAY STORES</u>		11. BIRTHPLACE (State or foreign country) <u>PENN.</u>	
13. FATHER'S NAME <u>JAMES WILSON</u>		14. MOTHER'S MAIDEN NAME <u>ANN FREEMAN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>233164190</u>	
17. INFORMANT <u>PATIENT'S RECORDS - 7600 CARD AVE.</u>		Address <u>TAKOMA PK., MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Intracranial Hemorrhage (Subarachnoid)</u> <u>330X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Gasch</u> M.D.		22. DATE SIGNED <u>Nov. 4, 1966</u>	
EXAMINER'S NAME (Type) <u>BELDEN R. GASCH M.D.</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) _____	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>Nov 8, 1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington Virginia</u>
24. FUNERAL DIRECTOR <u>F. Gasch's Sons</u> <u>Hyattsville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 7 1966</u>	25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>

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WILLIAM STANLEY STANLEY

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MD  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15933

CERTIFICATE OF DEATH

15934

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>10 hrs - 3 min</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Laithersburg, Md.</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>40 N. Deepark Drive</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>THOMAS WAYNE POWELL</u>		4. DATE OF DEATH <u>November 28 1966</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>November 27, 1964</u>	
9. AGE (In years last birthday) <u>2</u> yrs.		10. IF UNDER 1 YEAR Months <u>10</u> Days <u>3</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery Co, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Ronald D. Powell</u>		14. MOTHER'S MAIDEN NAME <u>Carolyn Patricia Penn</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Ronald D. Powell</u>		Address <u>Laithersburg, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			
PART I. DEATH WAS CAUSED BY:			
IMMEDIATE CAUSE (a) <u>Prematurity</u>			
762.5 DUE TO			
(b) <u>Resorption Atelectases</u>			
DUE TO			
(c)			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/27</u> , 19 <u>66</u> , to <u>11/28</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11/28/66</u> and that death occurred at <u>4:05 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Richard J. Hollander</u>		22b. DATE SIGNED <u>11/28/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Richard J. Hollander, M.D.</u>		22d. ADDRESS <u>1110 Spring Street, Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <u>Dec. 1, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>1331 Rockville Pike</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	
DATE <u>DEC 1 1966</u>			
Rockville, Md.			

10001

RECORD OF DEEDS

10001



Association and Records

Association and Records

Association and Records

Association and Records

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15934

## CERTIFICATE OF DEATH

15935

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Chevy Chase</b> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>3905 Oliver Street</b>		d. STREET ADDRESS <b>3905 Oliver Street</b>	
3. NAME OF DECEASED (Type or print) First <b>JAMES</b> Middle <b>EDWARD</b> Last <b>POWERS</b>		4. DATE OF DEATH Month <b>Nov.</b> Day <b>17,</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Feb. 23, 1910</b>
9. AGE (In years last birthday) <b>56</b>		IF UNDER 1 YEAR Months _____ Days _____	IF UNDER 24 HRS. Hours _____ Min. _____
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Auto-Salesman</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>John Powers</b>		14. MOTHER'S MAIDEN NAME <b>Catherine Touhy</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>577-10-6214</b>	
17. INFORMANT <b>Wife</b> Address <b>Angela R. Powers</b> Same as Item 2.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> DUE TO <b>with decompensation</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Fractured Ribs</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>2/3</b> , 19 <b>62</b> , to <b>11/17</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/17</b> , 19 <b>66</b> , and that death occurred at <b>11:30 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>A. C. Leonardo</b>		22b. DATE SIGNED <b>11/17/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>A. C. Leonardo</b>		22d. ADDRESS <b>5801 - 13th St. N. W. Washington, D. C.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-21-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 23 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12334

ORIGINAL OF DEED

12334



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15933

## CERTIFICATE OF DEATH

15937

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leesdale</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Chevy Chase</u> 15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>4608 Davidson Dr.</u>	
3. NAME OF DECEASED (Type or print) <u>Lillian</u> First <u>Puccell</u> Middle <u>Lucell</u> Last		4. DATE OF DEATH Month <u>11</u> Day <u>2</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-15-94</u> 12 yrs.
9. AGE (In years last birthday) <u>72</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>2</u> Hours <u>15</u> Min. <u>15</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Wash. D.C.</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>James Charles Puccell</u>		14. MOTHER'S MAIDEN NAME <u>Virginia Fitzgerald</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-48-2406T</u>	
17. INFORMANT <u>Sister - Mrs. Oakman - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>5410 Duodenal ulcer E hemorrhage</u> DUE TO (b) <u>3 weeks</u> DUE TO (c) <u>INTERVAL BETWEEN ONSET AND DEATH</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Congestive heart failure 6 months</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <u>19</u> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>10/21, 1966</u> to <u>Nov 2, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 2, 1966</u> , and that death occurred at <u>12 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Dr Joseph Kenrick</u>		22b. DATE SIGNED <u>11/2/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr JOSEPH KENRICK</u>		22d. ADDRESS <u>6450 Wisconsin Ave, Bethesda Md.</u>	
23a. BURIAL CREMATION, REMOVAL (Specify)	23b. DATE THEREOF <u>11-5-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>11th St. O level</u>	23d. LOCATION (City or Town) (County) (State) <u>Wash. D.C.</u>
24. FUNERAL DIRECTOR <u>Wanlon Funeral Home</u>		25a. REC'D BY REGISTRAR <u>Wash. D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 16 1966</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and any event, within 72 hours after death.

1203

2628

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15936

CERTIFICATE OF DEATH

15938

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>36 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Maryland</b>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>St. Mary's</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Chaptico</b> d. STREET ADDRESS <b>(No street address)</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last <b>Hattie Cecelia Quade</b>				4. DATE OF DEATH Month Day Year <b>November 11 19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>16 December 1897</b>	
9. AGE (In years last birthday) <b>68 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b></b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>George W. Owens</b>				14. MOTHER'S MAIDEN NAME <b>Agnes Lacey</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>The Medical Records, The Clinical Center, Bethesda 14, Maryland</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Hodgkin's Disease</b> <b>201X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						INTERVAL BETWEEN ONSET AND DEATH <b>1 1/2 years</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>6 October</b> , 19 <b>66</b> , to <b>11 November 66</b> , that <del>we</del> last saw the deceased alive on <b>11 November 19 66</b> , and that death occurred at <b>4:20 A.M.</b> the causes and on the date stated above.							
22a. SIGNATURE <b>Herbert E. Kann, Jr., MD</b>						22b. DATE SIGNED <b>11 Nov. 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Herbert E. Kann, Jr., MD</b>						22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 14, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Sacred Heart Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bushwood, Maryland</b>	
24. FUNERAL DIRECTOR <b>W. Clarke Mattingley</b>				25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>			
ADDRESS <b>Leonardtoun, Maryland</b>				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

15332

15332

The Clinical Center, Bethesda, MD, Maryland (in street address)

George A. Lewis

November 11, 1955

The Clinical Center, Bethesda, MD, Maryland

November 11, 1955

The Clinical Center, Bethesda, MD, Maryland

November 11, 1955

The Clinical Center, Bethesda, MD, Maryland

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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1

(M)

70

2

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15937

CERTIFICATE OF DEATH

15939

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
c. LENGTH OF STAY IN 1b <u>12 days</u>		d. STREET ADDRESS <u>5514 Johnson Ave.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Anna H. Ralston</u>		4. DATE OF DEATH <u>11-3-66</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-5-14</u>
9. AGE (In years last birthday) <u>51</u> yrs.		10. IF UNDER 1 YEAR: Months <u>11</u> Days <u>3</u> Hours <u>19</u> Min. <u>66</u>	
11a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home-maker</u>		11b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>	
13. FATHER'S NAME <u>Thomas M. Hodges</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Hyger</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>208-03-4857</u>	
17. INFORMANT <u>John - husband - Same</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Amyotrophic Lateral Sclerosis</u> <u>3561</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) _____ (c) _____			INTERVAL BETWEEN ONSET AND DEATH <u>3 months</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) _____ (County) _____ (State) _____
21. I certify that (I) (this hospital) attended the deceased from <u>Sept</u> , 19 <u>66</u> , to <u>2 Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>2 Nov</u> , 19 <u>66</u> , and that death occurred at <u>8:30</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Horace W. Bernton</u>		22b. DATE SIGNED <u>3 Nov '66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HORACE W. BERNTON</u>		22d. ADDRESS <u>4743 Bradley Blvd. Chevy Chase, Maryland</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>	23b. DATE THEREOF <u>11-4-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	23d. LOCATION (City or Town) <u>Suitland, Maryland</u> (County) _____ (State) _____
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 10 1966</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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BRITISH COLUMBIA

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*[Faint, illegible text and markings covering the majority of the page, likely bleed-through from the reverse side.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death.

Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MDARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15938

CERTIFICATE OF DEATH

15941

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Pennsylvania</b> b. COUNTY <b>Knottingham</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN 1b <b>12 hrs 45 min</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Knottingham</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>Route 2, Box 216</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <b>Terri Lynne REUSTLE</b>				4. DATE OF DEATH Month Day Year <b>November 15 19 66</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Cauc.</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov. 14, 1966</b>	
9. AGE (In years last birthday) yrs. <b>19</b>		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>N/A</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Bainbridge, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>				13. FATHER'S NAME <b>Albert C. Reustle</b>			
14. MOTHER'S MAIDEN NAME <b>Norma Kay Trout</b>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>N/A</b>			
16. SOCIAL SECURITY NO. <b>N/A</b>				17. INFORMANT <b>Hospital Records</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary atelectasis</b> DUE TO (b) <b>Hyaline membrane disease</b> DUE TO (c) <b></b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 14</b> , 19 <b>66</b> to <b>Nov. 15</b> , 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 15</b> , 19 <b>66</b> , and that death occurred at <b>1245</b> M, from causes and on the date stated above.							
22a. SIGNATURE <i>Jerry J. Tomasovic</i>				22b. DATE SIGNED <b>A</b>		22c. PHYSICIAN'S NAME (Type) <b>Jerry J. Tomasovic M. D.</b>	
22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>				23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			
23b. DATE THEREOF <b>Nov. 18, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Baltimore National</b>		23d. LOCATION (City or Town) (County) (State) <b>Baltimore, Maryland</b>			
24. FUNERAL DIRECTOR <b>Laurel Funeral Home</b> ADDRESS <b>550 Washington Blvd. Laurel, Maryland</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 28 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



15341

CENTRAL OF GREAT

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If possible, please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15939

## CERTIFICATE OF DEATH

15942

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> M.D. MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Frederick</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>				c. LENGTH OF STAY IN 1b <u>11-1-66 to</u>			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Frederick</u>				d. STREET ADDRESS <u>106 Mt. Olivet Blvd</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Randolph Hills Nursing Home</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>L. Grace</u> Middle <u>GRACE</u> Last <u>Rhodes</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>23</u> Year <u>19 66</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1-9-1879</u>	
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Patent Stenographer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u></u>		11. BIRTHPLACE (County & State, or foreign country) <u>Pennsylvania</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>Henry B. Rhodes</u>				14. MOTHER'S MAIDEN NAME <u>Doris Jane Stuegis</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>				16. SOCIAL SECURITY NO. <u>577-48-3125</u>		17. INFORMANT <u>Miss Doris Baker</u> Address <u>3432 Stonehall Drive Beltsville, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatosis</u> <u>170x</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Breast</u> DUE TO (c) <u></u>							INTERVAL BETWEEN ONSET AND DEATH <u>3 yrs</u> <u>1 yr</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Generalized Arteriosclerosis</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u></u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>11/2</u> , 19 <u>66</u> , to <u>11/23</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11/22</u> , 19 <u>66</u> , and that death occurred at <u>2:30 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>Raymond T. Benack</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/23/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>				22d. ADDRESS <u>4115 Colie Drive Wheaton Md.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/26/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Maria</u>		23d. LOCATION (City or Town) (County) (State) <u>Smithfield, Pennsylvania</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home-1331 Rockville Pike Rockville, Md.</u>				24a. REC'D BY REGISTRAR <u>NOV 25 1966</u> DATE		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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CONCORDIA DE VILLAS

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE  
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15940

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15943

1. PLACE OF DEATH a. COUNTY <b>Montgomery County</b>		2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring, Md.</b>		c. LENGTH OF STAY IN 1b <b>15-1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hosp</b>		d. STREET ADDRESS <b>3 Crest Pkwy, SS, Md.</b>	
3. NAME OF DECEASED (Type or print) <b>Carlos</b>		4. DATE OF DEATH Month <b>11</b> Day <b>27</b> Year <b>1966</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/15/17</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Asst Naval Attache, Peruvian Embassy</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Lima, Peru</b>	
11. BIRTHPLACE (State or foreign country) <b>Lima, Peru</b>		12. CITIZEN OF WHAT COUNTRY? <b>Peru</b>	
13. FATHER'S NAME <b>Carlos Risco, Sr.</b>		14. MOTHER'S MAIDEN NAME <b>Aurora Bohl</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>in Peruvian Navy</b>		16. SOCIAL SECURITY NO. <b>Rosa Risco</b>	
17. INFORMANT <b>Wife,</b> <b>Rosa Risco</b>		Address <b>Same address</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Coronary Insufficiency</b> <b>4201</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Coronary Artery Heart Disease</b> DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Diabetes Mellitus</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Nat While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>		22. DATE SIGNED <b>Nov. 27, 1966</b>	
ACTUAL SIGNATURE <b>Belden R. Leap</b> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/> <b>Wheaton, Maryland</b>	
EXAMINER'S NAME (Type) <b>BELDEN R. LEAP, M.D.</b>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>Wheaton, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 12-2-66</b>		23b. DATE THEREOF <b>12-2-66</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Lima, Peru</b>		23d. LOCATION (City or Town) (County) (State) <b>Lima, Peru, So.Amer.</b>	
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 29 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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General Company, New York  
New York, N.Y.

Respectfully,  
The Vice President

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## CERTIFICATE OF DEATH

Reg. Dist. No. 15944

15941

1. PLACE OF DEATH o. COUNTY MONTGOMERY MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE MARYLAND b. COUNTY HOWARD			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) OLNEY				c. LENGTH OF STAY IN 1b I DAY		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) SYKESVILLE	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION MONTGOMERY GENERAL HOSPITAL				d. STREET ADDRESS STAR ROUTE #1		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print)		First JOHN		Middle HENRY		Last ROBERTS	
4. DATE OF DEATH		Month NOVEMBER		Day 15		Year 19 66	
5. SEX MALE	6. COLOR OR RACE WHITE	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 3-28-10		9. AGE (In years last birthday) 56 yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) CABINET MAKER		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) MARYLAND		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME WILLIAM ROBERTS				14. MOTHER'S MAIDEN NAME SARAH ROBERTSON			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT MONTGOMERY GEN. HOSP. OLNEY, MD.		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 5271 DUE TO Brochopneumonia, later (b) EMPHYSEMA, SEVERE (c) DUE TO CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST. PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 11/14/66 to 11/15/66, that I last saw the deceased alive on 11/14/66, and that death occurred on 11/15/66, from the causes and on the date stated above. ACTUAL SIGNATURE C. H. LIGON, M.D. DATE SIGNED 11/15/66 ADDRESS (Street, city or town, state) Sandy Spring Md.							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 11/17/66		22c. NAME OF CEMETERY OR CREMATORY Parklawn		22d. LOCATION (City, town, or county) (State) Rockville, Maryland	
23. FUNERAL DIRECTOR'S SIGNATURE Tyson Wheeler Funeral Home				ADDRESS 1331 Rockville Pike Rockville, Md.		24b. REGISTRAR'S SIGNATURE Charles Judge	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

15941

# CERTIFICATE OF DEATH

15941

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED		DATE OF DEATH		PLACE OF DEATH	
JAMES H. HOOKER		JAN 10 1941		BALTIMORE, MARYLAND	
AGE		SEX		RACE	
68		M		W	
BIRTH DATE		BIRTH PLACE		MARRIAGE DATE	
JAN 10 1872		BALTIMORE, MARYLAND		JAN 10 1900	
OCCUPATION		CAUSE OF DEATH		MANNER OF DEATH	
RETIRED		HEART DISEASE		NATURAL	
PREVIOUS ILLNESS		SIGNS AND SYMPTOMS		TREATMENT	
NONE		PAIN IN CHEST, SHORTNESS OF BREATH		MEDICINE	
DATE OF BURIAL		PLACE OF BURIAL		NAME OF FUNERAL HOME	
JAN 12 1941		BALTIMORE, MARYLAND		JAMES H. HOOKER	
SIGNATURE OF DECEASED		SIGNATURE OF WITNESSES		SIGNATURE OF PHYSICIAN	
JAMES H. HOOKER		JAMES H. HOOKER		JAMES H. HOOKER	
DATE OF SIGNATURE		DATE OF SIGNATURE		DATE OF SIGNATURE	
JAN 10 1941		JAN 10 1941		JAN 10 1941	

RECEIVED  
JAN 10 1941  
BALTIMORE, MARYLAND



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 8 Film G383 11/25/66 mh

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15942

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health at its designated agent, prior to burial, cremation, or removal, and in an envelope within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>4743 Bradley Blvd apt 204</u>		d. STREET ADDRESS <u>4743 Bradley Blvd apt 204</u>	
3. NAME OF DECEASED (Type or print) First <u>Violet</u> Middle <u>Elizabeth</u> Last <u>Roman</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>Fe</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/25/1911</u> AGE (In years last birthday) <u>54</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Budget Analyst</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U. S. Govt</u>	
11. BIRTHPLACE (State or foreign country) <u>Roanoke, Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>(Unknown) Oliff</u>		14. MOTHER'S MAIDEN NAME <u>Bertha A. (Unknown)</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <u>579-42-0862</u>	
17. INFORMANT <u>Son</u> <u>Robert C. Roman</u>		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxia</u> DUE TO <u>due to strangulation</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>due to strangulation</u> DUE TO (c) <u>Sudden</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Beaten and strangled in kitchen of apt. by her son</u>	
20c. TIME OF INJURY Month, Day, Year <u>6:48</u> Hour <u>am</u> <u>11</u> <u>8</u> <u>1966</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, form, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> M.D.		22. DATE SIGNED <u>11/10/66</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-15-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25. REC'D BY REGISTRAR <u>Nov 14 1966</u> DATE	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

1001

1001

# MARYLAND STATE DEPARTMENT OF HEALTH

## DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15943

### CERTIFICATE OF DEATH

15946

<b>1. PLACE OF DEATH</b> <b>a. COUNTY</b> MONTGOMERY MARYLAND <b>b. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) Silver Spring <b>c. LENGTH OF STAY IN 1b</b> 2 days <b>d. NAME OF HOSPITAL OR INSTITUTION</b> (if not in hospital, give street address) HOLY CROSS HOSPITAL		<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) <b>a. STATE</b> MARYLAND <b>b. COUNTY</b> MONTGOMERY <b>c. CITY OR TOWN</b> (if outside corporate limits, write RURAL and give nearest town) Silver Spring <b>d. STREET ADDRESS</b> SILVER SPRING, MD. <b>e. IS RESIDENCE ON A FARM?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last Robert William L. ROSANO <b>5. SEX</b> MALE <b>6. COLOR OR RACE</b> CAUC. <b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>4. DATE OF DEATH</b> Month Day Year 11 24 1966 <b>8. DATE OF BIRTH</b> 5/9/15 <b>9. AGE</b> (In years last birthday) 51 yrs. <b>IF UNDER 1 YEAR</b> Months Days Hours Min. <b>IF UNDER 24 HRS.</b>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) Chief of Real Estate <b>10b. KIND OF BUSINESS OR INDUSTRY</b> U S Government <b>11. BIRTHPLACE</b> (County & State, or foreign country) New York <b>12. CITIZEN OF WHAT COUNTRY?</b> U.S.A.		<b>13. FATHER'S NAME</b> Vincent M. Rosano <b>14. MOTHER'S MAIDEN NAME</b> Mary C Cammarata	
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service) no <b>16. SOCIAL SECURITY NO.</b> 088 03 7754-- <b>17. INFORMANT</b> Rose G Rosano <b>Address</b> Silver Springs, Md.		<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c.)] <b>PART I. DEATH WAS CAUSED BY:</b> <b>IMMEDIATE CAUSE (a)</b> Acute anteroseptal myocardial infarction 4201 <b>CONDITIONS, If any, which gave rise to immediate cause (a), stating the underlying cause last.</b> <b>(b)</b> Coronary Thrombosis <b>(c)</b> Coronary atherosclerosis <b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b> <b>19. WAS AUTOPSY PERFORMED?</b> YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. 19 <b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <b>20f. (City or town)</b> (County) (State) New 22, 1966, to Nov 24, 1966, that (I) (we) last saw the deceased alive on Nov 23 1966, and that death occurred at 3:30 P.M. from the causes and on the date stated above.	
<b>21. I certify that (I) (this hospital) attended the deceased from</b> Nov 22, 1966, to Nov 24, 1966, that (I) (we) last saw the deceased alive on Nov 23 1966, and that death occurred at 3:30 P.M. from the causes and on the date stated above.		<b>22a. SIGNATURE</b> George Sharpe <b>22c. PHYSICIAN'S NAME</b> (Type) GEORGE SHARPE <b>22d. ADDRESS</b> Kensington, Md. <b>22b. DATE SIGNED</b> 11/24/66	
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> Burial <b>23b. DATE THEREOF</b> Nov 28, 1966. <b>23c. NAME OF CEMETERY OR CREMATORY</b> Gate of Heaven Cemetery <b>23d. LOCATION</b> (City, town or county) (State) Wheaton Montgomery Md.		<b>24. FUNERAL DIRECTOR</b> F. Gasch's Sons <b>ADDRESS</b> Hyattsville, Maryland. <b>25a. REC'D BY REGISTRAR</b> DATE NOV 28 1966 <b>25b. REGISTRAR'S SIGNATURE</b> Charles Judge	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3522

10

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND													
15944					15947								
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>								
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b <u>3 years 3 mo 30 days</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>								
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>					d. STREET ADDRESS <u>507 Leighton Avenue</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>William G. Rose Sr</u>			First Middle Last		4. DATE OF DEATH <u>November 20 1966</u>			Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>January 11 1895</u>		9. AGE (In years last birthday) <u>71</u> yrs. IF UNDER 1 YEAR: Months Days Hours Min.					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Accountant</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>G. H. O.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>				
13. FATHER'S NAME <u>Clarence J. Rose</u>					14. MOTHER'S MAIDEN NAME <u>Elizabeth Sweeney</u>								
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>			16. SOCIAL SECURITY NO. <u>WW 11 221-30-5251</u>		17. INFORMANT <u>William G. Rose, Jr.</u>			Address <u>507 Leighton Ave. Silver Spring, Md.</u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction</u> <u>4222</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Pneumonia</u> DUE TO (c)								INTERVAL BETWEEN ONSET AND DEATH <u>12 hrs</u> <u>3-4 days</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Cerebral hemorrhage sodium causes of 2nd infarct 54 hrs death</u>										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>June 1962</u> , to <u>Nov 20, 1966</u> , that (I) (we) last saw the deceased alive on <u>Nov 19 1966</u> , and that death occurred at <u>11 A</u> M, from the causes and on the date stated above.										22a. SIGNATURE <u>William B. Wardrop</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>William B. Wardrop</u>			M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22d. ADDRESS <u>808 Pershury Drive Beltsville Md</u>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>Nov. 23, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National Cem.</u>			23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>					
24. FUNERAL DIRECTOR <u>John B. Thomas</u>			ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>John B. Thomas</u>			25b. REGISTRAR'S SIGNATURE <u>John B. Thomas</u>					

DATE

NOV 22 1966

Charles Judge

3521

5261

**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
6M 1/66

15945

**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

15948

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Sakoma Park</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Wash. San. &amp; Hospital</u>		d. STREET ADDRESS <u>10618 Glenwild Road</u>	
3. NAME OF DECEASED (Type or print) <u>JACK</u> First <u>ROSENsky</u> Middle <u>ROSENsky</u> Last		4. DATE OF DEATH <u>Nov.</u> Month <u>8</u> Day <u>19</u> Year <u>66</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>Cauc.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5-30-12</u> 9. AGE (In years last birthday) <u>54</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life even if retired) <u>Real Estate Sales</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>REAL ESTATE</u>	11. BIRTHPLACE (State or foreign country) <u>New York</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		13. FATHER'S NAME <u>Samuel Rosensky</u>	
14. MOTHER'S MAIDEN NAME <u>Ida Sherman</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>	
16. SOCIAL SECURITY NO. <u>579-01-8769</u>		17. INFORMANT <u>HOSP. RECORDS</u> Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4201 Acute coronary insufficiency</u> DUE TO (b) <u>Coronary artery heart disease</u> DUE TO (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.	20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> at work Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>Belden R. Reap</u> EXAMINER'S NAME (Type) <u>BELDEN R. REAP M.D.</u>	CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22. DATE SIGNED <u>Nov. 8, 1966</u>
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL 11/10/66</u>	23b. DATE THEREOF <u>11/10/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>D.C. LODGE CEM.</u>	23d. LOCATION (City or Town) (County) (State) <u>WASH. D.C.</u>
24. FUNERAL DIRECTOR <u>GOLDBERG FUNERAL HOME, ST. N. W.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>



1991

FOR STATE  
HEALTH DEPT

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15946

15940

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>15.1</u> years	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>6006 Conway Rd.</u>		d. STREET ADDRESS <u>6006 Conway Rd.</u>	
3. NAME OF DECEASED (Type or print) <u>George W. Rothkopf</u> First Middle Last		4. DATE OF DEATH <u>Nov 27 1966</u> Month Day Year	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11/24/93</u>
9. AGE (In years last birthday) <u>73</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager-Life Ins. Co. -Retired</u>	
11. BIRTHPLACE (State or foreign country) <u>Missouri</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME (Unknown) <u>Rothkopf</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u> (If yes give war or dates of service) <u>WW I</u>		16. SOCIAL SECURITY NO. <u>577-10-6088</u>	
17. INFORMANT <u>Daughter</u> Address <u>Same as Item 2.</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Asphyxiation</u> <u>420.1</u> DUE TO <u>aspiration gastric contents</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) <u>myocardial infarction</u> DUE TO (c)	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>11/28/66</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-1-66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Arlington, Virginia</u>	
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>DEC 5 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15240

15240

15240

Male White

Married 1910

(1910)

Yes

Occupation

Registration Station

Specialized Information

John A. Hall

1910-1911

Primary, Secondary, Tertiary

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

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1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15947 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15949

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington, Maryland</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>10423 Fawcett Street</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington, Maryland 20795</b> d. STREET ADDRESS <b>10423 Fawcett Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Joseph D. Royer Jr.</b>		4. DATE OF DEATH <b>November 19 1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 2, 1895</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret. Race Horse Trainer</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Gaylord, Virginia</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Joseph D. Royer</b>		14. MOTHER'S MAIDEN NAME <b>Virgie Belle Conard</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>WW I 084 18 3945</b>	
17. INFORMANT <b>Mrs. M. Josephine Royer (Same as item #1)</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4201 Coronary Insufficiency Acute</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>cardio Vascular Disease.</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <b>John G. Ball</b>		M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> <b>11/20/66</b> 22. DATE SIGNED	
EXAMINER'S NAME (Type) <b>Dr. John G. Ball</b>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <b>7936 Old Geogtwn.</b> Address (Street, city, town, or county) <b>Bethesda, Md. Pa</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/23/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mount Olivet Cemetery</b>	23d. LOCATION (City, town or county) (State) <b>Frederick, Md. 21701</b>
24. FUNERAL DIRECTOR <b>M. R. Etchison &amp; Son, Frederick, Md. 21701</b>		25a. REC'D BY REGISTRAR <b>NOV 23 1966</b> 25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15948

CERTIFICATE OF DEATH

15950

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>MONTGOMERY</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>			c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Wheaton</u>			15.1
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington San. &amp; Hosp</u>				d. STREET ADDRESS <u>12414 Connecticut Ave</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <u>GRACE</u> Middle <u>LEE</u> Last <u>Russell</u>				4. DATE OF DEATH Month <u>11</u> Day <u>29</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>9-26-94</u>		9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Host</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>AMERICAN</u>	
13. FATHER'S NAME <u>GEORGE Brill</u>				14. MOTHER'S MAIDEN NAME <u>Molly Orendorff</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>-</u>		17. INFORMANT <u>CHART</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Pseudo Rabies Virus</u> <u>332X</u> DUE TO <u>Old tuberculosis (cured) &amp; R L Cerebral thrombosis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>Cerebral Arteriosclerosis</u> (c) <u>Cerebral Arteriosclerosis</u>							INTERVAL BETWEEN ONSET AND DEATH <u>small</u> <u>yes</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH (BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a))							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>10/30/66</u>		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/30/66</u> , 19 <u>66</u> , to <u>11/29</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/29</u> , 19 <u>66</u> , and that death occurred at <u>8:30</u> P.M., from causes and on the date stated above.							
22a. SIGNATURE <u>Chas H Wolcott</u>						22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Chas H Wolcott</u>				22d. ADDRESS <u>831 Univ Blvd &amp; SS NW</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12-2-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Nat'l. Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington, Va.</u>	
24. FUNERAL DIRECTOR <u>Joseph Fowler's Son</u>				ADDRESS <u>Wash., D.C.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 1 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15350

CERTIFICATE OF DESIGN

15350



*[Faint, mostly illegible text and markings, possibly a technical drawing or descriptive text, covering the majority of the page.]*



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15949

CERTIFICATE OF DEATH

15951

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>California</b> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Palm Springs</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		d. STREET ADDRESS <b>640 Warm Sands Drive</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Daniel</b> Middle <b>Webster</b> Last <b>RYAN</b>		4. DATE OF DEATH Month <b>November</b> Day <b>13</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Nov. 22, 1899</b>
9. AGE (In years last birthday) <b>66</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>U. S. Navy</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>Edgewood, Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Frank Ryan</b>		14. MOTHER'S MAIDEN NAME <b>Florence Barr</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>yes</b>		16. SOCIAL SECURITY NO.	
17. INFORMANT <b>Palm Springs</b> Address <b>California</b> <b>Mrs. Marjorie Ryan, 640 Warm Sands Drive</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction, posterior left ventricular wall</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>Nov. 5, 1966</b> to <b>Nov. 13, 1966</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>Nov. 13, 1966</b> , and that death occurred at <b>335P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>Hubert R. Brown Jr.</b>		22b. DATE SIGNED <b>Nov. 14, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. R. BROWN, JR., M. D.</b>		22d. ADDRESS <b>Naval Hospital, Bethesda, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-16, 66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Greenwood Memorial</b>	23d. LOCATION (City or Town) (County) (State) <b>San Diego, California</b>
24. FUNERAL DIRECTOR <b>Robert A. Pumphrey Funeral Home</b> <b>7557 Wisconsin Ave., Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 21 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	



**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

**15950**

**CERTIFICATE OF DEATH**

**15952**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>Fairfax</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN 1b <b>32 days</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>MCLEAN</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>1935 Rockingham St.</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Anne Robinson SAVIDGE</b>				4. DATE OF DEATH Month <b>November</b> Day <b>12</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Caucasian</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>19 July 1914</b>		9. AGE (In years lost birthday) yrs. <b>52</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washburn, Wisconsin</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Dwight S. ROBINSON</b>				14. MOTHER'S MAIDEN NAME <b>Ruth ELLIS</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>409 01 2651</b>		17. INFORMANT <b>1935 Address Rockingham St.</b> <b>William L. SAVIDGE, Mclean, Virginia</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Liver</b> <b>1561</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. _____ p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>10 Oct</b> , 19 <b>66</b> , to <b>12 Nov</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>12 Nov</b> , 19 <b>66</b> , and that death occurred at <b>10:08</b> , from causes and on the date stated above.							
22a. SIGNATURE <i>H. E. Ashworth</i>				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>12 Nov 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>H. E. ASHWORTH</b>				22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, or other disposal (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-16-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <i>Ben F. Rogers Jr.</i> <b>IVES, 2847 Wilson Blvd., Arlington, Va.</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 16 1966</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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IV-2, 2047 Wilson Blvd., Arlington, Va.

Arlington National

Arlington, Va.

H. F. ARNOLD

U.S. Naval Hospital, Bethesda, Md.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15951

CERTIFICATE OF DEATH

15953

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital of Silver Spring</u>		d. STREET ADDRESS <u>414 Irwin Street</u>	
3. NAME OF DECEASED (Type or print) First <u>MARY</u> Middle <u>A.</u> Last <u>SCHANTZ</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>8</u> Year <u>1966</u>	
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>CAU</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>11-8-04</u>
9. AGE (In years last birthday) <u>62</u> yrs.		10. IF UNDER 1 YEAR Months <u>62</u> Days <u>62</u> Hours <u>62</u> Min. <u>62</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>PENNSYLVANIA</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>MORACE GUTELIUS</u>		14. MOTHER'S MAIDEN NAME <u>FLORENCE THOMPSON</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>	
17. INFORMANT <u>WILMER S. SCHANTZ</u>		Address <u>SEE ITEM #2</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>4200</u> DUE TO <u>ASHD</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>—</u> DUE TO <u>—</u> (c) <u>—</u> DUE TO <u>—</u>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m. <u>—</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>Oct 6</u> , 19 <u>66</u> , to <u>Nov. 8</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov. 8</u> , 19 <u>66</u> , and that death occurred at <u>10<sup>00</sup></u> P.M. from causes and on the date stated above.			
22a. SIGNATURE <u>Raymond Bradshaw, Jr.</u>		22b. DATE SIGNED <u>Nov. 8, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>Raymond Bradshaw, Jr., M.D.</u>		22d. ADDRESS <u>345 University Blvd. Silver Spring, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-11-1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rock Creek Cemetery</u>	23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>
24. FUNERAL DIRECTOR <u>Joseph Burk's Sons</u>		25a. REC'D BY REGISTRAR <u>Wash., D.C.</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 18 1966</u>	

15322

CENTRIFUGAL OF DEATH

15321

Concussion, Head, Silver

ASAP

15321-15322  
Silver, Head, Concussion



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
15M 4-64

15952

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15954

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> c. LENGTH OF STAY IN 1b <b>MARYLAND</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>4305 Glenrose Street</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Kensington</b> d. STREET ADDRESS <b>4305 Glenrose Street</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>RAY MARTIN SCHENCK</b> First Middle Last		4. DATE OF DEATH <b>Nov. 4, 1966</b> Month Day Year	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Mar. 23, 1898</b> yrs. 68
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Landscape Architect</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Govt</b>	11. BIRTHPLACE (County & State, or foreign country) <b>Michigan</b>
13. FATHER'S NAME <b>Fred E. Schenck</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b> WW I		16. SOCIAL SECURITY NO. <b>578-32-4547</b>	
17. INFORMANT <b>Wife</b>		Address <b>Mildred D. Schenck Same as Item 2.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, (b) DUE TO (c) <b>163X</b>			INTERVAL BETWEEN ONSET AND DEATH <b>2 years</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>—</b> 19 <b>66</b> p.m. <b>—</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>February 4, 1960, to November 4, 1966</b> , that (I) <del>(we)</del> last saw the deceased alive on <b>Nov. 2, 1966</b> , and that death occurred at <b>7 P.M.</b> from the causes and on the date stated above.			
22a. SIGNATURE <b>Thomas S. Sappington</b>		M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>	22b. DATE SIGNED <b>Nov 4, 1966</b>
22c. PHYSICIAN'S NAME (Type) <b>THOMAS S. SAPPINGTON</b>		22d. ADDRESS <b>3546 Raymor Road Kensington, Maryland</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-9-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington Natl Cemetery, Arlington, Virginia</b>	23d. LOCATION (City, town or county) (State)
24. FUNERAL DIRECTOR <b>ROBERT A. PUMPHREY, Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>NOV 10 1966</b> 25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



1001

1002

40

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15953

15955

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>19 Days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Illinois</b>		b. COUNTY <b>Cary</b>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Cary</b>		d. STREET ADDRESS <b>R.R. #1, Box 582A</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) <b>Reginald Willard Sexton</b>		4. DATE OF DEATH Month <b>November</b>		Day <b>6</b>		Year <b>19 66</b>		5. SEX <b>M</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <b>28 November 1941</b>		9. AGE (In years last birthday) <b>24</b> yrs.		10. IF UNDER 1 YEAR Months <b>11</b>		Days <b>8</b>		Hours <b>11</b>		Min. <b>11</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Butcher</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Super Market</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <b>Reginald A. Sexton</b>		14. MOTHER'S MAIDEN NAME <b>Marcella Ziessey</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>349-34-6716</b>		17. INFORMANT <b>The Medical Records, The Clinical Center, Bethesda, Maryland</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia</b> DUE TO (b) <b>Hodgkin's Disease</b> DUE TO (c) <b>201X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		INTERVAL BETWEEN ONSET AND DEATH <b>12 Hours</b> <b>4 Months</b>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																							
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		21. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>18 October</b> , 19 <b>66</b> , to <b>6 November</b> 19 <b>66</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>6 November</b> 19 <b>66</b> , and that death occurred at <b>7:10 AM</b> , from the causes and on the date stated above.		22a. SIGNATURE <b>Jerry L. Spivak</b>		22b. DATE SIGNED <b>6 Nov. 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>Jerry L. Spivak, MD.</b>		22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda, Maryland</b>									
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-9-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN CEMETERY</b>		23d. LOCATION (City, town or county) (State) <b>Barrington, Ill</b>		24. FUNERAL DIRECTOR <b>Robert A. Humphrey</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		25c. DATE <b>NOV 14 1966</b>											

15353

15353

Illinois

Illinois

City

19 May

Deborah

The Clinical Center, Bethesda, Maryland, N.E. 11, Box 504

Regional Office, Illinois, Chicago, Illinois, 60606

White

11 November 1964

Illinois

Superior, Illinois

Inspector

Re: [illegible]

Re: [illegible]

100-36-010 The Clinical Center, Bethesda, Maryland

Re: [illegible]

Re: [illegible]

11 November

6 November

The Clinical Center, Bethesda, Maryland  
Institution of Health, Bethesda, Maryland

James H. [illegible]

Washington, D.C.

11-2-64

100-36-010

Bethesda, MD

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15954

15956

<b>1. PLACE OF DEATH</b> a. COUNTY <u>MONTGOMERY</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda, Md.</u> c. LENGTH OF STAY IN 1b <u>10/19/66 to 11/18/66</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Resmor Sanitarium</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Georgetown, Maryland</u> d. STREET ADDRESS <u>Rt 1, Box 208.</u> 15-1 e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>3. NAME OF DECEASED</b> (Type or print) First Middle Last <u>George Shaffer</u>			<b>4. DATE OF DEATH</b> Month Day Year <u>11 18 19 66</u>				
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>W</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>3/1/76</u>		<b>9. AGE</b> (In years last birthday) <u>90</u> yrs.		
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> 		<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Md.</u>			
<b>13. FATHER'S NAME</b> <u>unknown</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>unknown</u>				
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown) (If yes give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT</b> Address <u>George Shaffer, Jr. Frederick, Md.</u>			
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Uremia</u> DUE TO (b) <u>Pulmonary Emphysema</u> DUE TO (c) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.					INTERVAL BETWEEN ONSET AND DEATH <u>48 hours</u> <u>years</u>		
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)</b>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> <b>OR CONTRIBUTING</b> <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)					
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)	<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>10/19</u> , 19 <u>66</u> , to <u>11/18</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/18</u> , 19 <u>66</u> , and that death occurred at <u>6:40 PM</u> , from causes and on the date stated above.			
<b>22a. SIGNATURE</b> <u>Stephen F. Verges</u> <b>22c. PHYSICIAN'S NAME</b> (Type) <u>Stephen F. Verges</u>			<b>22b. DATE SIGNED</b> <u>11-18-66</u> <b>22d. ADDRESS</b> <u>Resmor Sanitarium Bethesda, Maryland</u>				
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>11/25/66</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Locust Grove</u>	<b>23d. LOCATION</b> (City or Town) (County) (State) <u>Nr. Mt. Airy, Md.</u>				
<b>24. FUNERAL DIRECTOR'S ADDRESS</b> <u>Olin L. Molesworth, Damascus, Md.</u>			<b>25a. REC'D BY REGISTRAR</b> <u>NOV 28 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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15025

STATE OF TEXAS

15025

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Vertical text on the right margin, likely a page number or reference code.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15955

## CERTIFICATE OF DEATH

15957

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> c. LENGTH OF STAY IN 1b <u>18 days</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> <u>15-1</u> d. STREET ADDRESS <u>7820 Hampden Lane</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
<b>3. NAME OF DECEASED</b> (Type or print) First <u>JAMES</u> Middle <u>HUGH</u> Last <u>SHANNON</u>			<b>4. DATE OF DEATH</b> Month <u>Nov.</u> Day <u>10</u> Year <u>1966</u>									
<b>5. SEX</b> <u>male</u>	<b>6. COLOR OR RACE</b> <u>white</u>	<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>5-13-1891</u>	<b>9. AGE</b> (In years last birthday) <u>75</u> yrs. <table border="1" style="display: inline-table; vertical-align: top;"> <tr> <th colspan="2">IF UNDER 1 YEAR</th> <th colspan="2">IF UNDER 24 HRS.</th> </tr> <tr> <td>Months</td> <td>Days</td> <td>Hours</td> <td>Min.</td> </tr> </table>	IF UNDER 1 YEAR		IF UNDER 24 HRS.		Months	Days	Hours	Min.
IF UNDER 1 YEAR		IF UNDER 24 HRS.										
Months	Days	Hours	Min.									
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Retired-Manager-No. West. Nat. Ins. Co.</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Wisconsin</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>								
<b>13. FATHER'S NAME</b> <u>Sylvester Shannon</u>			<b>14. MOTHER'S MAIDEN NAME</b> <u>Josephine Flag Fletley</u>									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no or unknown) <u>YES</u> <u>W.W.I.</u>		<b>16. SOCIAL SECURITY NO.</b> <u>577-09-8258</u>		<b>17. INFORMANT</b> <u>Clare - wife - same</u>								
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>442X UREMIA</u> DUE TO (b) <u>CARDIO-VASCULAR RENAL DISEASE WITH</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (c) <u>STROKE</u> DUE TO					INTERVAL BETWEEN ONSET AND DEATH <u>10 DAYS</u>  <u>15 DAYS</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)										
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a.m. p.m. <u>19</u>	<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)	<b>20f. (City or town)</b> (County) (State)	<b>21. I certify that (I) (this hospital) attended the deceased from</b> <u>Dec</u> , 19 <u>52</u> , to <u>Nov</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov 9</u> , 19 <u>66</u> , and that death occurred at <u>10:24</u> AM, from causes and on the date stated above.								
<b>22a. SIGNATURE</b> <u>DR. J. I. DONOVAN</u>			<b>22b. DATE SIGNED</b> <u>11/10/66</u>									
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>DR. J. I. DONOVAN</u>			<b>22d. ADDRESS</b> <u>8218 WISCONSIN AVE BETHESDA</u>									
<b>23a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>	<b>23b. DATE THEREOF</b> <u>11-14-66</u>	<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>Arlington Natl Cem.</u>	<b>23d. LOCATION</b> (City or Town) (County) (State) <u>Arlington, Virginia</u>									
<b>24. FUNERAL DIRECTOR</b> <u>ROBERT A. PUMPHREY</u> <u>Bethesda, Md.</u>			<b>25a. REC'D BY REGISTRAR</b> DATE <u>NOV 18 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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15537

CONTINUATION OF REPORT

15537

THIS IS A CONTINUATION OF REPORT NO. 15537, DATED 10/1/50, AND IS NOT TO BE SEPARATED FROM THE ORIGINAL REPORT. IT IS TO BE FILED WITH THE ORIGINAL REPORT AND IS NOT TO BE REPRODUCED SEPARATELY.



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15956

## CERTIFICATE OF DEATH

15958

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY <b>✓</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN lb <b>71 days</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>McLean</b>		d. STREET ADDRESS <b>6504 Dryden Drive</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Margaret</b> Middle <b>Ruth</b> Last <b>SHARP</b>		4. DATE OF DEATH Month <b>November</b> Day <b>7</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 11, 1919</b>
9. AGE (In years lost birthday) <b>47</b> yrs.		IF UNDER 1 YEAR Months <b>4</b> Days <b>7</b> Hours <b>16</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>N/A</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Iowa</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Arthur Peterson</b>		14. MOTHER'S MAIDEN NAME <b>Margaret Dodge</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b> (If yes give war or dates of service) <b>N/A</b>		16. SOCIAL SECURITY NO. <b>N/A</b>	
17. INFORMANT <b>McLean</b> Address <b>Virginia</b> <b>Capt. Wallace E. Sharp, 6504 Dryden Drive</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Chronic Renal Failure</b> <b>5810</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Cirrhosis</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Aug. 28</b> , 19 <b>66</b> to <b>Nov. 7</b> , 19 <b>66</b> , that (we) last saw the deceased alive on <b>November 7</b> , 19 <b>66</b> , and that death occurred at <b>8:10 P</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>P. T. Kirchner</b>		22b. DATE SIGNED <b>Nov. 8, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>P. T. KIRCHNER, LT MC USN</b>		22d. ADDRESS <b>U. S. NAVAL HOSPITAL, BETHESDA, MD.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/12/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery, Arlington, Virginia</b>	
24. FUNERAL DIRECTOR <b>Murphy Funeral Home, 3524 Columbia Pike, Arlington, Virginia</b>		25. REC'D BY REGISTRAR <b>NOV 14 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

3200 Columbia Pike, Arlington, Virginia

Joseph P. Murphy, Jr.

Partial

Arlington National Cemetery, Arlington, Virginia

U. S. ARMY, ARMY MEDICAL CENTER

Nov. 6, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

Nov. 1, 1966

## CERTIFICATE OF DEATH

Reg. Dist. No. 15959

15957

1. PLACE OF DEATH		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY	Montgomery County MARYLAND	STATE	Maryland COUNTY Montgomery Co.
CITY (If outside corporate limits, write RURAL OR and give nearest town)	Takoma Park,	CITY (If outside corporate limits, write RURAL and give nearest town)	Takoma Park 1571
LENGTH OF STAY (in this place)	yrs.	STREET ADDRESS	8512 Glenview Ave.
HOSPITAL OR INSTITUTION OR STREET ADDRESS	8512 Glenview Ave.	STREET ADDRESS	8512 Glenview Ave.

3. NAME OF DECEASED (Type or Print)		4. DATE OF DEATH	
LENA PHIFER SHAWEN		Mar. 3 1968	
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH
FEMALE	WHITE	WIDOWED	JULY 16, 1886
9. AGE last birthday	10. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country)	12. CITIZEN OF WHAT COUNTRY?
80 yrs.	Housewife	Missouri	USA
13. FATHER'S NAME		14. MOTHER'S MAIDEN NAME	
Simon Bolivar Phifer		Belle Valentine Phifer	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.	
no		17. INFORMANT & ADDRESS	
		Mr. Eugene H. Phifer-Bro.- 5001-Palisade L Wash. D. C.	

I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A)		INTERVAL BETWEEN ONSET AND DEATH	
4201 ANTECEDENT CAUSE(S) DUE TO		5 min.	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.		5 min.	
(B)			
(C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Minute)	
21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?	

22. I hereby certify that I attended the deceased from 10-27, 1968, to 11-3, 1968, that I last saw the deceased alive on 11-3, 1968, and that death occurred at 10:30 M. from the causes and on the date stated above.			
SIGNATURE		DATE SIGNED	
[Signature]		M.D. 1919-Seminary Rd., Sil. Spg., Md - 3.68	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		NAME OF CEMETERY OR CREMATORY	
BURIAL		CEDAR HILL CEMETERY	
DATE THEREOF		LOCATION (City, town, or county) (State)	
NOV. 7, 1966		SUITLAND, MARYLAND	
24. REC'D BY REGISTRAR		25. FUNERAL DIRECTOR'S SIGNATURE	
REGISTRAR'S SIGNATURE		ADDRESS	
[Signature]		1300-N ST. NW WASH. D. C.	
DATE			
NOV 7 1966			

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15958

CERTIFICATE OF DEATH

15960

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> County MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>			c. LENGTH OF STAY IN 1b <u>28 hrs. 28 min</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>				d. STREET ADDRESS <u>5013 Flanders AVE</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>STEPHEN CHARLES SHEA</u>				4. DATE OF DEATH Month <u>November</u> Day <u>15</u> Year <u>1966</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Nov. 14, 1966</u>		9. AGE (In years lost birthday) yrs. <u>1</u>	IF UNDER 1 YEAR Months <u>1</u> Days <u>1</u> Hours <u>1</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <u>Montgomery County - Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>DANIEL F SHEA</u>				14. MOTHER'S MAIDEN NAME <u>Jeanne Egan</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? <u>NO</u> (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT <u>Father same above item # 2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: <u>7545</u> IMMEDIATE CAUSE (a) <u>Congestive Heart Failure</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>11-14</u> , 19 <u>66</u> , to <u>11-15</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11-15</u> , 19 <u>66</u> , and that death occurred at <u>9:55</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Robert T Scanlon</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Robert T/ Scanlon</u>				22d. ADDRESS <u>5406 Connecticut Ave., N.W.</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/18/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Arlington National</u>		23d. LOCATION (City or Town) (County) (State) <u>Arlington Va.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler</u>				25a. REC'D BY REGISTRAR DATE <u>NOV 18 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15330

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TO THE DIRECTOR, BUREAU OF LAND MANAGEMENT  
FROM THE REGIONAL DIRECTOR, SOUTHWEST REGION  
SUBJECT: [Illegible]  
DATE: [Illegible]

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and at any event, within 72 hours after death.

VR A15 (4)  
20 M 1/66

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15959

CERTIFICATE OF DEATH

15961

1. PLACE OF DEATH a. COUNTY <i>Montgomery</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <i>De.</i> b. COUNTY	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>BETHESDA</i>		c. LENGTH OF STAY IN lb <i>15 MIN</i>	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Washington, D.C.</i> <i>47-3</i>
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <i>Suburban Hospital</i>		d. STREET ADDRESS <i>4831-36<sup>th</sup> St N.W. Apt 106</i>	e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) <i>Curtis Fay Shields</i>		4. DATE OF DEATH Month <i>Nov.</i> Day <i>20</i> Year <i>1966</i>	
5. SEX <i>male</i>	6. COLOR OR RACE <i>white</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <i>Oct. 6, 1895</i>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Retired</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Delivery of Congress</i>	9. AGE (In years lost birthday) yrs. <i>71</i>
11. BIRTHPLACE (County & State, or foreign country) <i>Pope County, North Carolina</i>		12. CITIZEN OF WHAT COUNTRY? <i>USA.</i>	
13. FATHER'S NAME <i>Eli Shields</i>		14. MOTHER'S MAIDEN NAME <i>Paris, Talulla</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <i>yes</i> <i>WWI -</i>		16. SOCIAL SECURITY NO. <i>579-32-2678</i>	
17. INFORMANT <i>Bessie C. Shields - wife - Add. same</i>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>420.1</i> <i>Coronary occlusion</i> DUE TO (b) <i>Myocardial infarction</i> DUE TO (c) <i>5 Weeks</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.		INTERVAL BETWEEN ONSET AND DEATH <i>5 Weeks</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <i>19</i> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <i>oct</i> , 19 <i>66</i> , to <i>nov 20</i> , 19 <i>66</i> , that (I) ( <i>we</i> ) last saw the deceased alive on <i>11-20</i> 19 <i>66</i> , and that death occurred at <i>3:45 AM</i> , from causes and on the date stated above.			
22a. SIGNATURE <i>P.P. Andrews</i>		22b. DATE SIGNED <i>11-20-66</i>	
22c. PHYSICIAN'S NAME (Type) <i>P.P. Andrews, M.D.</i>		22d. ADDRESS <i>4201 Freedom St NW</i>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE THEREOF <i>11/23/66</i>	23c. NAME OF CEMETERY OR CREMATORY <i>Arlington Nat. Cem.</i>
23d. LOCATION (City or Town) (County) (State) <i>Arlington, Va.</i>			
24. FUNERAL DIRECTOR <i>Joseph Gawler's Sons, Washington, D.C.</i>		25a. REC'D BY REGISTRAR DATE <i>NOV 23 1966</i>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



13021

UNITED STATES DEPARTMENT OF AGRICULTURE

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RECEIVED  
U. S. DEPARTMENT OF AGRICULTURE  
WASHINGTON, D. C.  
JAN 10 1910

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15960

CERTIFICATE OF DEATH

15962

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN IL <u>3 days</u>		
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Derwood</u>		1571		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Montgomery General Hospital</u>		d. STREET ADDRESS <u>6901 Garrett Road</u>		
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED (Type or print) First <u>Amos</u> Middle <u>Loy</u> Last <u>SHIPE</u>		4. DATE OF DEATH Month <u>11</u> Day <u>6</u> Year <u>1966</u>		
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4/10/1884</u>	
9. AGE (In years last birthday) <u>82</u> yrs.		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		
11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>		
13. FATHER'S NAME <u>Lorenzo Dahl Shipe</u>		14. MOTHER'S MAIDEN NAME <u>Matilda Cullers</u>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>NO</u>		16. SOCIAL SECURITY NO. <u>  </u>		
17. INFORMANT <u>Hospital Records Olney, Md.</u>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Apoplexy, Hemorrhagia</u> DUE TO (b) <u>Arterio-sclerotic cardiovascular disease</u> DUE TO (c) <u>  </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>4221</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>15 yrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>  </u> , 19 <u>  </u> , to <u>  </u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>19 66</u> , and that death occurred at <u>9:00 PM</u> , from causes and on the date stated above.				
22a. SIGNATURE <u>A. Dement Bonifant</u>		22b. DATE SIGNED		
22c. PHYSICIAN'S NAME (Type) <u>A. Dement Bonifant, M.D.</u>		22d. ADDRESS <u>Sandy Spring, Maryland</u>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-9-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Parklawn</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Mont. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis H. Barber Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 10 1966</u>		
		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		

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STATION OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15961

## CERTIFICATE OF DEATH

15963

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>		c. LENGTH OF STAY IN 1b <b>DOA</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>		d. STREET ADDRESS <b>6901 Garrett Rd.</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HARRIET</b> Middle <b>ELIZABETH</b> Last <b>SHIPE</b>		4. DATE OF DEATH Month <b>11</b> Day <b>4</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/16/1888</b>
9. AGE (In years last birthday) yrs. <b>78</b>		10. IF UNDER 1 YEAR Months <b>4</b> Days <b>19</b> Hours <b>66</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>J. M. Isenberg</b>		14. MOTHER'S MAIDEN NAME <b>Sallie Fought</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>-</b>	
17. INFORMANT <b>Mildred L. Ryan, 224 Great Falls Rd.</b>		Address <b>Rockville, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden pulmonary edema</b> DUE TO (b) <b>Arteriosclerotic cardiac vascular disease</b> DUE TO (c) <b>15 yrs</b>		INTERVAL BETWEEN ONSET AND DEATH <b>15 yrs</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Jan</b> , 19 <b>48</b> , to <b>Nov</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Nov 1</b> , 19 <b>66</b> , and that death occurred at <b>11:50 P</b> M, from causes and on the date stated above.			
22a. SIGNATURE <b>A. Dement Bonifant</b>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <b>A. Dement Bonifant, M.D.</b>		22d. ADDRESS <b>Medical Center, Sandy Springs, Md. 20860</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-9-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn</b>	23d. LOCATION (City or Town) (County) (State) <b>Rockville Mont Md.</b>
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR <b>Charles Judge</b>	
ADDRESS <b>Baytonsville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

13331

CENTRAL OF GEORGIA

13331

8

8

HOURS

NO

Rockville Road Md.

Parkview

11-0-0

Capital

Frederick E. Barber - Rockville, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1 (M)

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15962

CERTIFICATE OF DEATH

15964

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington</u>			
c. LENGTH OF STAY IN <u>3 Mos 3 DAs</u>				d. STREET ADDRESS <u>3508 39th Street NW</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS SANITARIUM</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Ruth B. SHIPLEY</u>				4. DATE OF DEATH <u>Nov 3 1966</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Apr 20 1885</u>	
9. AGE (In years last birthday) <u>81</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired - Dir. of Passports</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>MARYLAND</u>		11. BIRTHPLACE (County & State, or foreign country) <u>U.S.A.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>				13. FATHER'S NAME <u>ALEX BIELASKI</u>			
14. MOTHER'S MAIDEN NAME <u>ROSELLE ISRAEL</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>			
16. SOCIAL SECURITY NO. <u>- -</u>				17. INFORMANT <u>Col. F.W. SHIPLEY</u> Address <u>8345 Orange Ct. Alex, Va.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART I. DEATH WAS CAUSED BY:							
IMMEDIATE CAUSE (a) <u>Myocardial infarction</u>							
DUE TO (b) <u>Coronary arteriosclerosis</u>							
DUE TO (c) <u>6 months</u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
<u>Cerebral arteriosclerosis, severe</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.			
20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work				20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			
20f. (City or town) (County) (State)				21. I certify that (I) (this hospital) attended the deceased from <u>Oct 11, 1966</u> to <u>Nov 3, 1966</u> that (I) (we) last saw the deceased alive on <u>Nov 3rd 1966</u> , and that death occurred at <u>1300 PM</u> , from causes and on the date stated above.			
22a. SIGNATURE <u>Thomas A. Wildman</u>				22b. DATE SIGNED <u>Nov 3, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>Thomas A. Wildman</u>				22d. ADDRESS <u>3729 Morrison St. N.W. Wash. DC</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-7-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Congressional Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Washington D.C.</u>	
24. FUNERAL DIRECTOR <u>JOE. GAWLER'S SONS INC.</u>				25a. REC'D BY REGISTRAR <u>NOV 7 1966</u>			
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>							



15064

EXHIBIT OF DEED

15064

THE STATE OF TEXAS, COUNTY OF DALLAS, BEFORE ME, the undersigned authority, on this day personally appeared \_\_\_\_\_, known to me to be the person whose name is subscribed to the foregoing instrument, acknowledged to me that he executed the same for the purposes and consideration therein expressed.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15963

CERTIFICATE OF DEATH

15965

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Prince George</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>SILVER SPRING</u>				c. LENGTH OF STAY IN 1b <u>6 mos. 8 days</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>FAIRLAND ARSG HOME 201 FAIRLAND ROAD</u>				d. STREET ADDRESS <u>2510 AFTON STREET S.E.</u>			
3. NAME OF DECEASED (Type or print) First <u>HARRIET</u> Middle <u>L</u> Last <u>SHULL</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>20</u> Year <u>1966</u>			
5. SEX <u>FEMALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <u>MARCH 31 1881</u>		9. AGE (In years last birthday) <u>85 yrs.</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALES LADY</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Dept Store</u>		11. BIRTHPLACE (County & State, or foreign country) <u>MARYLAND, Allegany Co.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>JOSEPH S.W. HARRIS</u>				14. MOTHER'S MAIDEN NAME <u>PRITCHARD, Elizabeth</u>			
15. WAS DECEASED EVER IN U.S. ARMOED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>no</u>		16. SOCIAL SECURITY NO. <u>564-22-7897</u>		17. INFORMANT <u>Margaret P. Higdon Same as #2</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>6000</u> DUE TO <u>Acute Fulminating Pyelonephritis</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Acute Fulminating Pyelonephritis</u> (c) <u>Generalized ATERIOSclerosis, Congestive Heart Failure</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized ATERIOSclerosis, Congestive Heart Failure</u>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>5/12</u> , 19 <u>66</u> , to <u>11/20</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/20</u> 19 <u>66</u> , and that death occurred at <u>9:45</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>Raymond T. Benack MD</u>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>11/20/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>RAYMOND T. BENACK MD</u>				22d. ADDRESS <u>4115 Colie Drive, Wheaton, MD</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/22/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln</u>		23d. LOCATION (City or Town) (County) (State) <u>Colmar Manor P.G. Md.</u>	
24. FUNERAL DIRECTOR <u>Francis Gasch's Sons Hyattsville, Md.</u>				25. REC'D BY REGISTRAR <u>NOV 21 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

13863

CHARTER OF RIGHTS

13863

Pro. No.

13863

13863

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
CERTIFICATE OF DEATH											
1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Brookville</u> c. LENGTH OF STAY IN 1b <u>Life</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>DAMASCUS Road</u>						2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Rural - Brookville</u> d. STREET ADDRESS <u>DAMASCUS Road</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
3. NAME OF DECEASED (Type or print) <u>HERBERT P. Simms</u> First Middle Last						4. DATE OF DEATH <u>Nov. 1, 1966</u> Month Day Year					
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3-3-1907</u>		9. AGE (In years last birthday) <u>59</u> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Carpenter</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Building</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Md.</u>			12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>		
13. FATHER'S NAME <u>Charles Simms</u>						14. MOTHER'S MAIDEN NAME <u>Olive Haines</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>214-14-9332</u>		17. INFORMANT <u>Mrs. Irene Simms - Brookville, Md.</u> Address					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinoma of the bladder, post operative</u> 1810 DUE TO (b) <u>with metastasis to the liver, brain</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u>Anemia, Emaciation</u> INTERVAL BETWEEN ONSET AND DEATH <u>1964 through Nov. 1, 1966</u>											
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)											
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)							
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21. I certify that (I) (this hospital) attended the deceased from <u>Oct.</u> , 19 <u>64</u> , to <u>Nov. 1</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Nov. 1</u> , 19 <u>66</u> , and that death occurred at <u>6: P.M.</u> from the causes and on the date stated above.											
22a. SIGNATURE <u>Howard E. Hall</u> 22c. PHYSICIAN'S NAME (Type) <u>Howard E. Hall, M.D.</u>						22b. DATE SIGNED <u>Nov. 2, 1966</u> 22d. ADDRESS <u>Sykesville, Maryland</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>			23b. DATE THEREOF <u>11-4-66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Tennings Chapel</u>			23d. LOCATION (City, town or county) (State) <u>Howard County Md.</u>			
24. FUNERAL DIRECTOR <u>Harry W. Haight</u> ADDRESS <u>Sykesville, Md.</u>						25a. REC'D BY REGISTRAR <u>NOV 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

15386

15386

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

Filed by Dr. Leap

MEDICAL CERTIFICATION

1

M

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

15965

15967

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		c. LENGTH OF STAY IN lb <b>DOA</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>		d. STREET ADDRESS <b>716 McNeill Lane</b>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>HELEN Elizabeth</b> Middle <b>SIMON</b> Last <b>SIMON</b>		4. DATE OF DEATH Month <b>NOV</b> Day <b>13</b> Year <b>1966</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/10/92</b>
9. AGE (In years last birthday) <b>74</b> yrs.		10. IF UNDER 1 YEAR Months <b>13</b> Days <b>19</b> Hours <b>06</b> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Dickson City, Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Thomas Krasko</b>		14. MOTHER'S MAIDEN NAME <b>unavailable</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b> <b>None</b>		16. SOCIAL SECURITY NO. <b>718-05-7286D</b>	
17. INFORMANT <b>Daughter, Mrs. Gogalski, Frank</b>		Address <b>716 McNeill Ln. Silver Spring, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>CORONARY OCCLUSION</b> DUE TO <b>4201</b> (b) <b>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE 15 YEARS</b> DUE TO <b>15 YEARS</b> (c) <b>15 YEARS</b>		INTERVAL BETWEEN ONSET AND DEATH <b>45 minutes</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>DIABETES MELLITUS</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg, etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>OCT 24, 1966</b> to <b>NOV 13, 1966</b> that (I) (we) lost saw the deceased alive on <b>OCT 24, 1966</b> , and that death occurred at <b>7:30 P.M.</b> from causes and on the date stated above.			
22a. SIGNATURE <b>Robert L. Krackmar</b>		22b. DATE SIGNED <b>NOV 13 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>ROBERT L. KRACKMAR MD.</b>		22d. ADDRESS <b>7733 ALASKA AVENUE NW WASHINGTON DC 20012</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov. 16, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR <b>C. Glen Carter</b>		25a. REC'D BY REGISTRAR <b>DATE NOV 16 1966</b>	
25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>			

5221

53421

162-5



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, or in any event, within 72 hours after death.

1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15966

CERTIFICATE OF DEATH

15968

1. PLACE OF DEATH a. COUNTY <u>Maryland</u> <u>Montgomery</u> MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u> c. LENGTH OF STAY IN 1b <u>Unknown</u> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>River Oaks Farm</u>				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> <u>Montgomery</u> b. COUNTY c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Potomac</u> d. STREET ADDRESS <u>River Oaks Farm</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Albert H. Smith</u>				4. DATE OF DEATH <u>November 25</u> 19 <u>66</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-12-1910</u>		9. AGE (In years last birthday) <u>56</u> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Realtor</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>- - - -</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Jasper A. Smith</u>				14. MOTHER'S MAIDEN NAME <u>Bertha Parsons</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No.</u>		16. SOCIAL SECURITY NO. <u>- - - -</u>		17. INFORMANT <u>Mrs. Vena S. Smith- See Item No.2.</u> Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Adenocarcinoma Pancreas</u> <u>157X</u> - DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>with liver metastases</u> DUE TO (c) <u>-</u>						INTERVAL BETWEEN ONSET AND DEATH <u>6 weeks</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>10/11</u> , 19 <u>66</u> , to <u>11/25</u> , 19 <u>66</u> , that (I) ( <u>was</u> ) last saw the deceased alive on <u>11/23</u> , 19 <u>66</u> , and that death occurred at <u>10A-M</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>J. Blaine Fitzgerald</u>				22b. DATE SIGNED <u>11/25/66</u>		22c. PHYSICIAN'S NAME (Type) <u>Dr. J. Blaine Fitzgerald</u>	
22d. ADDRESS <u>8218 Wisc. Ave. Bethesda, Md.</u>				22e. M.D. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11-28-1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Ft. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges, Md.</u>	
24. FUNERAL DIRECTOR <u>Joseph Gawler's Sons, Inc</u> ADDRESS <u>5130 Wisc. Ave. N.W. Wash. D.C.</u>				25a. REC'D BY REGISTRAR <u>DEC 1 1966</u>		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

15008

DEPARTMENT OF HEALTH

15008

NAME OF PATIENT

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

SEX

RACE

CAUSE OF DEATH

DATE OF EXAMINATION

PLACE OF EXAMINATION

NAME OF PHYSICIAN

NAME OF HOSPITAL

NAME OF NURSE

NAME OF ASSISTANT

NAME OF ATTENDING

NAME OF SURGEON

NAME OF ANESTHETIC

NAME OF INSTRUMENT

NAME OF OPERATOR

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15967

## CERTIFICATE OF DEATH

15969

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>36 days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>Washington, D.C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Naval Hospital</b>				d. STREET ADDRESS <b>427 R Street, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>Geneva</b> Middle <b>Jemie</b> Last <b>SMITH</b>		4. DATE OF DEATH Month <b>Nov</b> Day <b>26</b> Year <b>1966</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negroid</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>27 Nov 1926</b>		9. AGE (In years last birthday) yrs. <b>39</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>—</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Akin, South Carolina</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>		13. FATHER'S NAME <del>Unknown</del> <b>James Smith</b>		14. MOTHER'S MAIDEN NAME <del>Unknown</del> <b>Bessie Andrews</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>—</b>		17. INFORMANT <b>Robert L. SMITH</b> address <b>427 R St., N.W. Washington, D.C. (Husband)</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Pulmonary emboli, multiple</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					INTERVAL BETWEEN ONSET AND DEATH
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>21 Oct</b> , 19 <b>66</b> , to <b>26 Nov</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>26 Nov</b> , 19 <b>66</b> , and that death occurred at <b>645P</b> M, from causes and on the date stated above.					
22a. SIGNATURE <i>John C. Mullen</i>		M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>27 Nov 66</b>	
22c. PHYSICIAN'S NAME (Type) <b>John C. MULLEN, LCDR MC USN</b>		22d. ADDRESS <b>U.S. Naval Hospital, Bethesda, Md.</b>			
23a. BURIAL, CREMATION, or other (Specify) <b>Burial</b>	23b. DATE THEREOF <b>12-1-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Va.</b>	
24. FUNERAL DIRECTOR <b>Malvan &amp; Schey</b>		ADDRESS <b>New Jersey Ave. at R. St. N.W., Washington D.C.</b>		25a. REC'D BY REGISTRAR DATE <b>DEC 2 1966</b>	25b. REGISTRAR'S SIGNATURE <i>Judge</i>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

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Items 18&21 Film 384 1-19-MARYLAND STATE DEPARTMENT OF HEALTH									
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Items 8,9 Film G383 11/25/66 mh									
15968 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 15970									
1. PLACE OF DEATH a. COUNTY Montgomery					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE Md.				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton, Md.					c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Wheaton				
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross Hospital					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
3. NAME OF DECEASED First Middle Last Jean E. Smith					4. DATE OF DEATH Month Day Year 11 20 66				
5. SEX f		6. COLOR OR RACE W		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 8/9/12 1911		9. AGE (In years) 54 yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) housewife				10b. KIND OF BUSINESS OR INDUSTRY Own Home		11. BIRTHPLACE (State or foreign country) Arkansas		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME David Evans					14. MOTHER'S MAIDEN NAME Anna Roberts				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) (If yes give war or dates of service) No None			16. SOCIAL SECURITY NO. Yes		17. INFORMANT Orson A. Smith				
Address 10803 Georgia Avenue Silver Spring, Wheaton, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Dehydration and hypovolemic shock due to 581.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Hyperemesis; DUE TO (c) Fatty Metamorphosis of Liver								INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(o)								19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)						
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. 19			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined monner <input type="checkbox"/>									
22. DATE SIGNED Nov. 20, 1966					23. CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
24. ACTUAL SIGNATURE EXAMINER'S NAME (Type) Belden R. Reap, M.D.					25. ADDRESS (City, town, or county) Arlington National Cem. Arlington, Virginia				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial			23b. DATE THEREOF Nov. 23, 1966		23c. NAME OF CEMETERY OR CREMATORY Arlington National Cem.		23d. LOCATION (City or Town) (County) (State) Arlington, Virginia		
24a. FUNERAL DIRECTOR Clark E. Wisor Warner C. Humphrey, Inc.					25a. REC'D BY REGISTRAR NOV 25 1966 DATE				
25b. REGISTRAR'S SIGNATURE Charles Judge									

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**MARYLAND STATE DEPARTMENT OF HEALTH**  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15969

**CERTIFICATE OF DEATH**

15971

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>DISTRICT</b> b. COUNTY <b>4859 Rockwood Pkwy. N.W. Dist. of Col.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Wheaton</b>			c. LENGTH OF STAY in lb <b>Oct. 27 - 11/8/66</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>University Nursing Home</b>				d. STREET ADDRESS <b>4859 Rockwood Pkwy</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <b>George</b> Middle <b>Edward</b> Last <b>Snyder</b>				4. DATE OF DEATH <b>Nov. 8</b> Day <b>8</b> Year <b>1966</b>			
5. SEX <b>M</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2/24/1880</b>		9. AGE (In years last birthday) yrs. <b>86</b>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Postmaster</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Randallstown, Balto. Co., Md.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>George Snyder</b>			14. MOTHER'S MAIDEN NAME <b>Wilhemina Newman</b>				
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>		16. SOCIAL SECURITY NO. <b>219-01-5667</b>		17. INFORMANT Address <b>West D.C 20016</b> <b>Mrs. Pauline Stow 4859 Rockwd. Pkwy. N.W.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma, larynx</b> <b>161X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>14 mos.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <b>Oct. 27</b> , 1966, to <b>Nov. 8</b> , 1966, that (I) (we) lost the deceased alive on <b>Nov. 8</b> , 1966, and that death occurred at <b>7:20 P.M.</b> , from causes on and on the date stated above.							
22a. SIGNATURE <b>A.W. Smith</b>			22b. DATE SIGNED <b>11/8/66</b>		22c. PHYSICIAN'S NAME (Type) <b>A.W. SMITH</b>		
22d. ADDRESS <b>13018 GEORGIA AVE WHEATON, MD.</b>			22e. MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>				
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11/11/66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Randallstown, Md. 21133</b>	
24. FUNERAL DIRECTOR <b>Loring Byers- 8728 Liberty Rd. Randallstown, Md.</b>				25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. These please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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University of Illinois at Chicago

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12345678910111213141516171819202122232425262728293031323334353637383940414243444546474849505152535455565758596061626364656667686970717273747576777879808182838485868788899091929394959697989910010110210310410510610710810911011111211311411511611711811912012112212312412512612712812913013113213313413513613713813914014114214314414514614714814915015115215315415515615715815916016116216316416516616716816917017117217317417517617717817918018118218318418518618718818919019119219319419519619719819920020120220320420520620720820921021121221321421521621721821922022122222322422522622722822923023123223323423523623723823924024124224324424524624724824925025125225325425525625725825926026126226326426526626726826927027127227327427527627727827928028128228328428528628728828929029129229329429529629729829930030130230330430530630730830931031131231331431531631731831932032132232332432532632732832933033133233333433533633733833934034134234334434534634734834935035135235335435535635735835936036136236336436536636736836937037137237337437537637737837938038138238338438538638738838939039139239339439539639739839940040140240340440540640740840941041141241341441541641741841942042142242342442542642742842943043143243343443543643743843944044144244344444544644744844945045145245345445545645745845946046146246346446546646746846947047147247347447547647747847948048148248348448548648748848949049149249349449549649749849950050150250350450550650750850951051151251351451551651751851952052152252352452552652752852953053153253353453553653753853954054154254354454554654754854955055155255355455555655755855956056156256356456556656756856957057157257357457557657757857958058158258358458558658758858959059159259359459559659759859960060160260360460560660760860961061161261361461561661761861962062162262362462562662762862963063163263363463563663763863964064164264364464564664764864965065165265365465565665765865966066166266366466566666766866967067167267367467567667767867968068168268368468568668768868969069169269369469569669769869970070170270370470570670770870971071171271371471571671771871972072172272372472572672772872973073173273373473573673773873974074174274374474574674774874975075175275375475575675775875976076176276376476576676776876977077177277377477577677777877978078178278378478578678778878979079179279379479579679779879980080180280380480580680780880981081181281381481581681781881982082182282382482582682782882983083183283383483583683783883984084184284384484584684784884985085185285385485585685785885986086186286386486586686786886987087187287387487587687787887988088188288388488588688788888989089189289389489589689789889990090190290390490590690790890991091191291391491591691791891992092192292392492592692792892993093193293393493593693793893994094194294394494594694794894995095195295395495595695795895996096196296396496596696796896997097197297397497597697797897998098198298398498598698798898999099199299399499599699799899910001001100210031004100510061007100810091010101110121013101410151016101710181019102010211022102310241025102610271028102910301031103210331034103510361037103810391040104110421043104410451046104710481049105010511052105310541055105610571058105910601061106210631064106510661067106810691070107110721073107410751076107710781079108010811082108310841085108610871088108910901091109210931094109510961097109810991100110111021103110411051106110711081109111011111112111311141115111611171118111911201121112211231124112511261127112811291130113111321133113411351136113711381139114011411142114311441145114611471148114911501151115211531154115511561157115811591160116111621163116411651166116711681169117011711172117311741175117611771178117911801181118211831184118511861187118811891190119111921193119411951196119711981199120012011202120312041205120612071208120912101211121212131214121512161217121812191220122112221223122412251226122712281229123012311232123312341235123612371238123912401241124212431244124512461247124812491250125112521253125412551256125712581259126012611262126312641265126612671268126912701271127212731274127512761277127812791280128112821283128412851286128712881289129012911292129312941295129612971298129913001

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TABLE 2

W. L. RYAN, Director, USDA, and J. H. HARRIS, Jr., Editor

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2000

**Abstract**

1997, 1998, 1999, 2000, 2001, 2002, 2003, 2004, 2005, 2006, 2007, 2008, 2009, 2010, 2011, 2012, 2013, 2014, 2015, 2016, 2017, 2018, 2019, 2020, 2021, 2022, 2023, 2024, 2025, 2026, 2027, 2028, 2029, 2030, 2031, 2032, 2033, 2034, 2035, 2036, 2037, 2038, 2039, 2040, 2041, 2042, 2043, 2044, 2045, 2046, 2047, 2048, 2049, 2050, 2051, 2052, 2053, 2054, 2055, 2056, 2057, 2058, 2059, 2060, 2061, 2062, 2063, 2064, 2065, 2066, 2067, 2068, 2069, 2070, 2071, 2072, 2073, 2074, 2075, 2076, 2077, 2078, 2079, 2080, 2081, 2082, 2083, 2084, 2085, 2086, 2087, 2088, 2089, 2090, 2091, 2092, 2093, 2094, 2095, 2096, 2097, 2098, 2099, 2100, 2101, 2102, 2103, 2104, 2105, 2106, 2107, 2108, 2109, 2110, 2111, 2112, 2113, 2114, 2115, 2116, 2117, 2118, 2119, 2120, 2121, 2122, 2123, 2124, 2125, 2126, 2127, 2128, 2129, 2130, 2131, 2132, 2133, 2134, 2135, 2136, 2137, 2138, 2139, 2140, 2141, 2142, 2143, 2144, 2145, 2146, 2147, 2148, 2149, 2150, 2151, 2152, 2153, 2154, 2155, 2156, 2157, 2158, 2159, 2160, 2161, 2162, 2163, 2164, 2165, 2166, 2167, 2168, 2169, 2170, 2171, 2172, 2173, 2174, 2175, 2176, 2177, 2178, 2179, 2180, 2181, 2182, 2183, 2184, 2185, 2186, 2187, 2188, 2189, 2190, 2191, 2192, 2193, 2194, 2195, 2196, 2197, 2198, 2199, 2200, 2201, 2202, 2203, 2204, 2205, 2206, 2207, 2208, 2209, 2210, 2211, 2212, 2213, 2214, 2215, 2216, 2217, 2218, 2219, 2220, 2221, 2222, 2223, 2224, 2225, 2226, 2227, 2228, 2229, 2230, 2231, 2232, 2233, 2234, 2235, 2236, 2237, 2238, 2239, 2240, 2241, 2242, 2243, 2244, 2245, 2246, 2247, 2248, 2249, 2250, 2251, 2252, 2253, 2254, 2255, 2256, 2257, 2258, 2259, 2260, 2261, 2262, 2263, 2264, 2265, 2266, 2267, 2268, 2269, 2270, 2271, 2272, 2273, 2274, 2275, 2276, 2277, 2278, 2279, 2280, 2281, 2282, 2283, 2284, 2285, 2286, 2287, 2288, 2289, 2290, 2291, 2292, 2293, 2294, 2295, 2296, 2297, 2298, 2299, 2300, 2301, 2302, 2303, 2304, 2305, 2306, 2307, 2308, 2309, 2310, 2311, 2312, 2313, 2314, 2315, 2316, 2317, 2318, 2319, 2320, 2321, 2322, 2323, 2324, 2325, 2326, 2327, 2328, 2329, 2330, 2331, 2332, 2333, 2334, 2335, 2336, 2337, 2338, 2339, 2340, 2341, 2342, 2343, 2344, 2345, 2346, 2347, 2348, 2349, 2350, 2351, 2352, 2353, 2354, 2355, 2356, 2357, 2358, 2359, 2360, 2361, 2362, 2363, 2364, 2365, 2366, 2367, 2368, 2369, 2370, 2371, 2372, 2373, 2374, 2375, 2376, 2377, 2378, 2379, 2380, 2381, 2382, 2383, 2384, 2385, 2386, 2387, 2388, 2389, 2390, 2391, 2392, 2393, 2394, 2395, 2396, 2397, 2398, 2399, 2400, 2401, 2402, 2403, 2404, 2405, 2406, 2407, 2408, 2409, 2410, 2411, 2412, 2413, 2414, 2415, 2416, 2417, 2418, 2419, 2420, 2421, 2422, 2423, 2424, 2425, 2426, 2427, 2428, 2429, 2430, 2431, 2432, 2433, 2434, 2435, 2436, 2437, 2438, 2439, 2440, 2441, 2442, 2443, 2444, 2445, 2446, 2447, 2448, 2449, 2450, 2451, 2452, 2453, 2454, 2455, 2456, 2457, 2458, 2459, 2460, 2461, 2462, 2463, 2464, 2465, 2466, 2467, 2468, 2469, 2470, 2471, 2472, 2473, 2474, 2475, 2476, 2477, 2478, 2479, 2480, 2481, 2482, 2483, 2484, 2485, 2486, 2487, 2488, 2489, 2490, 2491, 2492, 2493, 2494, 2495, 2496, 2497, 2498, 2499, 2500, 2501, 2502, 2503, 2504, 2505, 2506, 2507, 2508, 2509, 2510, 2511, 2512, 2513, 2514, 2515, 2516, 2517, 2518, 2519, 2520, 2521, 2522, 2523, 2524, 2525, 2526, 2527, 2528, 2529, 2530, 2531, 2532, 2533, 2534, 2535, 2536, 2537, 2538, 2539, 2540, 2541, 2542, 2543, 2544, 2545, 2546, 2547, 2548, 2549, 2550, 2551, 2552, 2553, 2554, 2555, 2556, 2557, 2558, 2559, 2560, 2561, 2562, 2563, 2564, 2565, 2566, 2567, 2568, 2569, 2570, 2571, 2572, 2573, 2574, 2575, 2576, 2577, 2578, 2579, 2580, 2581, 2582, 2583, 2584, 2585, 2586, 2587, 2588, 2589, 2590, 2591, 2592, 2593, 2594, 2595, 2596, 2597, 2598, 2599, 2600, 2601, 2602, 2603, 2604, 2605, 2606, 2607, 2608, 2609, 2610, 2611, 2612, 2613, 2614, 2615, 2616, 2617, 2618, 2619, 2620, 2621, 2622, 2623, 2624, 2625, 2626, 2627, 2628, 2629, 2630, 2631, 2632, 2633, 2634, 2635, 2636, 2637, 2638, 2639, 2640, 2641, 2642, 2643, 2644, 2645, 2646, 2647, 2648, 2649, 2650, 2651, 2652, 2653, 2654, 2655, 2656, 2657, 2658, 2659, 2660, 2661, 2662, 2663, 2664, 2665, 2666, 2667, 2668, 2669, 2670, 2671, 2672, 2673, 2674, 2675, 2676, 2677, 2678, 26

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15970

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15972

FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>DO A</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Mary</u> Middle <u>Elizabeth</u> Last <u>Snyder</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>12</u> Year <u>1966</u>	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>July 31, 1883</u>
9. AGE (In years lost birthday) <u>83</u> yrs.		10. IF UNDER 1 YEAR Months <u>0</u> Days <u>0</u> Hours <u>0</u> Min. <u>0</u>	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Home</u>		12. KIND OF BUSINESS OR INDUSTRY <u>—</u>	
13. BIRTHPLACE (State or foreign country) <u>Maryland (Mont Co)</u>		14. CITIZEN OF WHAT COUNTRY? <u>—</u>	
15. FATHER'S NAME <u>James Howes</u>		16. MOTHER'S MAIDEN NAME <u>Eliza Green</u>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>—</u> (If yes give war or dates of service)		18. SOCIAL SECURITY NO. <u>—</u>	
19. INFORMANT <u>—</u>		Address <u>—</u>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Insufficiency - Acute</u> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cardio Vascular Disease</u> DUE TO (c) <u>—</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Recent Fracture - Left Ankle - + Left Clavicle</u>			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input checked="" type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fall at Home Causing Fracture + Left ankle + Clavicle</u>	
20c. TIME OF INJURY Month, Day, Year Hour <u>9/22</u> 19 <u>66</u> early p.m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>	20f. (City or town) <u>Garthursburg</u> (County) <u>Mont</u> (State) <u>Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u> EXAMINER'S NAME (Type) <u>John G. Ball</u>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county) <u>11/12/66</u>	
22. DATE SIGNED <u>11/12/66</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-15-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Neelsville</u>	23d. LOCATION (City or Town) <u>Neelsville</u> (County) <u>Mont</u> (State) <u>Md.</u>
24. FUNERAL DIRECTOR <u>Francis H. Barber</u> ADDRESS <u>Laytonsville, Md.</u>		25a. REC'D BY REGISTRAR <u>NOV 16 1966</u>	25b. REGISTRAR'S SIGNATURE <u>John Charles Judge</u>

12835

12836

John C. Bell

Neelaville, Maine, Mo.

Neelaville

11-1-05

Francis H. Bell, Neelaville, Mo.

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Their please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

**MARYLAND STATE DEPARTMENT OF HEALTH**  
**DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND**

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>Maryland</b>		b. COUNTY <b>Prince Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillandale Silver Spring</b>		c. LENGTH OF STAY IN 1b <b>28 months</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Hillandale Silver Spring 15.1</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1014 Robroy Drive</b>		d. STREET ADDRESS <b>1014 Robroy Drive</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>John</b>		First <b>John</b>		Middle <b>E.</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>August 20, 1920</b>		9. AGE (In years last birthday) <b>46</b> yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
11. BIRTHPLACE (County & State, or foreign country) <b>Brooklyn, New York</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>		13. FATHER'S NAME <b>John Henry Softy</b>	
14. MOTHER'S MAIDEN NAME <b>Lillian H. Schmidt</b>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW II</b>		16. SOCIAL SECURITY NO. <b>057-12-6362</b>	
17. INFORMANT <b>Patricia J. Softy</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of Lung</b> <b>163X</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ _____ (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <b>16 months</b>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)		21. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that (I) (this hospital) attended the deceased from <b>November 10, 1966</b> , to <b>November 1, 1966</b> , that (I) (we) last saw the deceased alive on <b>October 31, 1966</b> , and that death occurred at <b>4</b> M., from the causes and on the date stated above.					
22a. SIGNATURE <b>[Signature]</b>		22b. DATE SIGNED <b>Nov 1, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>BLAINE H. EIG</b>	
22d. ADDRESS <b>8641 Colesville Rd Silver Spring Md.</b>		22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	
23b. DATE THEREOF <b>Nov. 4, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Covington Memorial Gardens</b>		23d. LOCATION (City, town or county) (State) <b>St. Wayne, Indiana</b>	
24. FUNERAL DIRECTOR <b>John B. Thomas Warner E. Humphrey, Inc.</b>		25a. REC'D BY REGISTRAR <b>NOV 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>[Signature]</b>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15972

15974

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY CO., MARYLAND</b>		2. USUAL RESIDENCE (Where deceased lived, If Institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>P. Georges</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BETHESDA</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>University PARK - HyattsVILLE</b>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>SUBURBAN HOSPITAL</b>		d. STREET ADDRESS <b>4216 Sheridan st.</b>	
3. NAME OF DECEASED (Type or print) <b>MAY Welling SOUDER</b>		4. DATE OF DEATH <b>Nov. 29 1966</b>	
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-7-1869</b>
9. AGE (In years last birthday) <b>97</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Home-maker Ret.</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At Home</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>Howard Co. MD</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>George Richardson</b>		14. MOTHER'S MAIDEN NAME <b>Laura Paynter</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>577-34-6832</b>	
17. INFORMANT <b>Son Oscar Souder</b>		Address <b>SAME</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>pneumonia</b> <b>493X</b> DUE TO Conditions, If any, which gave rise to immediate cause (a), stating the underlying cause last. (b) (c)		INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>A.S.H.D. - M. block</b>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNOERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Oct 1966</b> to <b>Nov. 1966</b> , that (I) (we) last saw the deceased alive on <b>Nov 28 1966</b> , and that death occurred at <b>3A</b> M, from the causes and on the date stated above.			
22a. SIGNATURE <b>Marvin Wadler, M.D.</b>		22b. DATE SIGNED <b>Nov. 29, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>MARVIN WADLER</b>		22d. ADDRESS <b>8218 Wisconsin Ave. N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 2, 1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Bladensburg, Maryland</b>	
24. FUNERAL DIRECTOR <b>W. W. CHAMBERS, Co. Riverdale, Md.</b>		25a. REC'D BY REGISTRAR <b>DEC 1 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15973

## CERTIFICATE OF DEATH

15975

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Montgomery</u> <span style="float: right;">MARYLAND</span> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Wheaton, Md.</u> c. LENGTH OF STAY IN lb <u>3 months</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>University Nursing Home 901 Arcola Ave.</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived, if institution: Residence before admission) a. STATE <u>Washington, D.C.</u> b. COUNTY <u>...</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>7410 Alaska Ave., N.W.</u> d. STREET ADDRESS e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>Anna</u> <u>nmn</u> <u>Steinman</u> First Middle Last				<b>4. DATE OF DEATH</b> <u>November 22 19 66</u> Month Day Year											
<b>5. SEX</b> <u>F</u>		<b>6. COLOR OR RACE</b> <u>Caus.</u>		<b>7. MARRIED</b> <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>5/1/03</u>		<b>9. AGE</b> (In years last birthday) <u>63 yrs.</u>		<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>H.W.</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b>				<b>11. BIRTHPLACE</b> (County & State, or foreign country) <u>Maryland</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Simon Edlavitch</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Elizabeth Edlavitch</u> (Maiden & Married same)									
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> Address							
<b>18. CAUSE OF DEATH</b> (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cancer of Brain</u> DUE TO (b) <u>1930</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>8 mos</u>			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
<b>20a. ACCIDENT WAS UNDERLYING</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)									
<b>20c. TIME OF INJURY</b> Month, Day, Year <u>11/20 1966</u>				<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> (County) (State)							
<b>21. I certify</b> that (I) (this hospital) attended the deceased from <u>March 18, 1966</u> to <u>11/22, 1966</u> , that (I) (we) last saw the deceased alive on <u>11/20, 1966</u> , and that death occurred at <u>7:00 AM</u> , from the causes and on the date stated above.															
<b>22a. SIGNATURE</b> <u>Cyril A. Schulman</u> M.D.						<b>ATTENDING PHYS.</b> <input checked="" type="checkbox"/> <b>MED. DIRECTOR</b> <input type="checkbox"/> <b>STAFF PHYS.</b> <input type="checkbox"/>		<b>22b. DATE SIGNED</b>							
<b>22c. PHYSICIAN'S NAME</b> (Type) <u>Cyril A. Schulman</u>						<b>22d. ADDRESS</b> <u>1801 Eye St N.W. Washington D.C.</u>									
<b>23a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>23b. DATE THEREOF</b> <u>11/23/66</u>		<b>23c. NAME OF CEMETERY OR CREMATORY</b> <u>King David Mem. Garden</u>				<b>23d. LOCATION</b> (City, town or county) (State) <u>Falls Church, Virginia</u>					
<b>24 FUNERAL DIRECTOR'S SIGNATURE</b> <u>Bernard Danzansky &amp; Sons St., N.W. Wash. D.C.</u>						<b>ADDRESS</b> <u>3501-14th</u>		<b>25a. REC'D BY REGISTRAR</b> <u>NOV 23 1966</u>		<b>25b. REGISTRAR'S SIGNATURE</b> <u>Charles Judge</u>					

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15974 CERTIFICATE OF DEATH 15976

1. PLACE OF DEATH a. COUNTY <del>XXXXXXX</del> <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>					
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>				c. LENGTH OF STAY IN 1b <u>2 Weeks</u>					
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Fairland Nursing Home</u>				d. STREET ADDRESS <u>1718 Priscilla Drive</u>					
3. NAME OF DECEASED (Type or print) First <u>GEORGE</u> Middle <u>WYMAN</u> Last <u>SWAIN</u>				4. DATE OF DEATH Month <u>Nov</u> Day <u>5</u> Year <u>1966</u>					
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>JUNE 30 1983</u>			
9. AGE (In years last birthday) <u>83</u> yrs.		IF UNDER 1 YEAR Months <u>8</u> Days <u>3</u> Hours <u>15</u> Min. <u>1</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Brooklyn, N. Y.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Life Insurance</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Actuary</u>					
13. FATHER'S NAME <u>Enoch Swain</u>				14. MOTHER'S MAIDEN NAME <u>Annie Wyman</u>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>199-09-3690</u>		17. INFORMANT <u>Bessie C. Swain</u>		Address <u>1718 Priscilla Dr. Silver Spring, Md.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CARDIAC ARREST</u> <u>4201</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>CORONARY HEART DISEASE</u> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>PARKINSON'S DISEASE</u>								INTERVAL BETWEEN ONSET AND DEATH <u>IMMEDIATE</u> <u>4 YRS</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)			
21. I certify that (I) (this hospital) attended the deceased from <u>JANUARY, 1963</u> , to <u>NOV 5, 1966</u> , that (I) last saw the deceased alive on <u>NOV 5, 1966</u> , and that death occurred at <u>5:40 P.M.</u> from the causes and on the date stated above.									
22a. SIGNATURE <u>Edward A. Beeman</u> M.D.				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>NOV 5, 1966</u>			
22c. PHYSICIAN'S NAME (Type) <u>EDWARD A. BEEMAN</u>				22d. ADDRESS <u>1015 SPRING ST. SILVER SPRING, MARYLAND</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Nov. 8, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>			
24. FUNERAL DIRECTOR <u>C. Glen Carter</u> <u>Warner E. Pumphrey, Inc.</u>				ADDRESS <u>8434 Georgia Ave. Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>			
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 9 1966</u>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15975

CERTIFICATE OF DEATH

15977

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Kensington</u>		c. LENGTH OF STAY IN 1b <u>1 mo. 2 days</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		15.1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Carroll Hall Sanitarium</u>		d. STREET ADDRESS <u>1523 East Faulkland Lane</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Elva Mae Taylor</u> First Middle Last		4. DATE OF DEATH <u>Nov 2</u> 19 <u>66</u> Month Day Year	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Feb. 9, 1897</u> 879
9. AGE (In years last birthday) <u>87</u> yrs.		IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Ret. Seamstress</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Sewing</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Knoxville, Tennessee</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>(Unknown) Comax</u>		14. MOTHER'S MAIDEN NAME <u>Anna Flippen</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>213-38-0993</u>	
17. INFORMANT <u>William F. Taylor</u>		Address <u>9906 Tenbrook Dr. Silver Spring, Md.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Thrombosis</u> 332 332 X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Arteriosclerosis</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>10/26/66</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardiovascular Disease</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1966</u> , to <u>Nov 2</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>Oct 31</u> 19 <u>66</u> , and that death occurred at <u>9:55 p.m.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>James W. Egan</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>James W. Egan</u>		22d. ADDRESS <u>5413 Cedar Lane, Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>Nov. 5, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>St. Lincoln Cemetery</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>C. Glen Carter</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>NOV 7 1966</u>	

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15976

15978

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Mont. Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Robert Raymond Taylor</u>		4. DATE OF DEATH Month <u>Nov</u> Day <u>3</u> Year <u>1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2/11/86</u>
9. AGE (In years last birthday) yrs. <u>80</u>		10. IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farming &amp; grain mill</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Maryland</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William R. Taylor</u>		14. MOTHER'S MAIDEN NAME <u>Florence Barrett</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>yes</u>		16. SOCIAL SECURITY NO. <u>217-05-6561</u>	
17. INFORMANT <u>Ruth E. Hayes</u>		Address <u>Same as above</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary artery insufficiency</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Coronary arteriosclerosis, severe</u> DUE TO (c) <u>  </u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>  </u>			
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>  </u> p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that (I) (this hospital) attended the deceased from <u>10/21/66</u> , 19 <u>  </u> to <u>11/3/66</u> , that (I) (we) last saw the deceased alive on <u>11/3/66</u> , 19 <u>  </u> , and that death occurred at <u>6:57</u> M, from causes and on the date stated above.			
22a. SIGNATURE <u>Timothy Tehan M.D.</u>		22b. DATE SIGNED <u>  </u>	
22c. PHYSICIAN'S NAME (Type) <u>Dr. Timothy Tehan</u>		22d. ADDRESS <u>8218 Wisconsin Ave., Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVED (Specify) <u>Buried</u>		23b. DATE THEREOF <u>11/7/66</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Harpers</u>		23d. LOCATION (City or Town) (County) (State) <u>Harpers Ferry, West Va.</u>	
24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 7 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15078

DEPARTMENT OF STATE

15078

11/2/50

10/1/50

11/3/50  
*Frank J. Jones*  
U.S. DEPT. OF STATE

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

15977

## CERTIFICATE OF DEATH

15979

Items 7, 8, 9 Fill G383 11/28/66 mh

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b>		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>TAKOMA PARK</b>		c. LENGTH OF STAY IN 1b <b>151</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>WASHINGTON SANITARY HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <b>LOUIS</b>		First Middle Last <b>TETTELBAUM</b>		4. DATE OF DEATH Month Day Year <b>NOVEMBER 20 19 66</b>	
5. SEX <b>M</b>	6. COLOR OR RACE <b>white</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>7 - ? - 1888</b>	9. AGE (In years last birthday) <b>78 yrs.</b>	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>GROCCER</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>POLAND</b>	
13. FATHER'S NAME <b>JACOB TETTELBAUM</b>		14. MOTHER'S MAIDEN NAME <b>LILY TETTELBAUM</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>NO</b>		16. SOCIAL SECURITY NO. <b>NO</b>		17. INFORMANT <b>SON</b> Address <b>JACK TETTELBAUM - 1160 FILLMORE DR. M.D.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Acute Myocardial Infarction</b> 4201 DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>Arteriosclerotic Heart Disease</b> (a), stating the underlying cause last. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Chemia, Diabetes mellitus Aortic Aneurysm</b>					INTERVAL BETWEEN ONSET AND DEATH <b>1 m med. ill over 5 years</b>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>2601-16th Street, N.W. Wash. DC</b>	
21. I certify that (I) (this hospital) attended the deceased on <b>Jan 1, 1966</b> to <b>Nov 20, 1966</b> that (I) (we) last saw the deceased alive on <b>Nov 19, 1966</b> , and that death occurred at <b>1:50 P.M.</b> from the causes and on the date stated above.					
22a. SIGNATURE <b>Warren D. Brill, M.D.</b>		22b. DATE SIGNED <b>Nov 20, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>WARREN D. Brill, M.D.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-21-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>BETH SHOLOM CEM.</b>	
23d. LOCATION (City, town or county) <b>HILLSIDE MD</b>		23e. NAME OF CEMETERY OR CREMATORY <b>BETH SHOLOM CEM.</b>		23f. LOCATION (City, town or county) <b>HILLSIDE MD</b>	
24. FUNERAL DIRECTOR'S SIGNATURE <b>BERNARD DANZANSKY &amp; SONS - WASHINGTON DC</b>		25a. REC'D BY REGISTRAR <b>NOV 22 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MEDICAL CERTIFICATION

15033

15033

GROCE

TEST

10



# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15978

15980

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Pro George's</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Silver Springs Md.</b>				c. LENGTH OF STAY IN 1b			
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Greenbelt, Md.</b>				d. STREET ADDRESS <b>62 E Ridge Road</b>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Holy Cross Hospital</b>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>Brian</b> Middle <b>D</b> Last <b>Timmons</b>				4. DATE OF DEATH Month <b>November</b> Day <b>13</b> , Year <b>19 66</b>			
5. SEX <b>male</b>		6. COLOR OR RACE <b>white</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>Nov 10, 1966</b>	
9. AGE (In years lost birthday) yrs.		IF UNDER 1 YEAR Months <b>3</b> Days <b>3</b> Hours <b>3</b> Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>--</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>--</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Maryland</b>	
12. CITIZEN OF WHAT COUNTRY? <b>U S A</b>							
13. FATHER'S NAME <b>Ronald Timmons</b>				14. MOTHER'S MAIDEN NAME <b>Linda L Strang</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>no</b>				16. SOCIAL SECURITY NO. <b>None</b>		17. INFORMANT <b>Ronald Timmons</b> Address <b>Greenbelt, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Sudden death of undetermined cause</b> <b>7730</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>(Crib Death)</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-11</b> , 19 <b>66</b> , to <b>11-13</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>11-12</b> 19 <b>66</b> , and that death occurred at <b>3 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>Andrew G. Aronfy</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-14-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Andrew G. Aronfy</b>				22d. ADDRESS <b>6803 Good Luck Rd. New Carrollton Md 20784</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Nov 17, 1966</b>		23c. NAME OF CEMETERY OR CREMATORIUM <b>Ft Lincoln Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Colmar Manor Pro Geo Md.</b>	
24. FUNERAL DIRECTOR <b>F. Gasch's Sons</b>				ADDRESS <b>Hyattsville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 17 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

Medical examiner of Montgomery County notified and approved Dr. Elden Reap Wheaton, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15578

CERTIFICATE OF DEATH

15578

Name of Deceased		Date of Birth		Sex	
Place of Birth		Date of Death		Time of Death	
Cause of Death		Place of Death		Manner of Death	
Signature of Registrar		Signature of Medical Officer		Signature of Coroner	
Signature of Deceased		Signature of Next of Kin		Signature of Witnesses	
Signature of Priest		Signature of Minister		Signature of Chaplain	
Signature of Undertaker		Signature of Burial Officer		Signature of Cemetery Officer	
Signature of Registrar		Signature of Medical Officer		Signature of Coroner	
Signature of Deceased		Signature of Next of Kin		Signature of Witnesses	
Signature of Priest		Signature of Minister		Signature of Chaplain	
Signature of Undertaker		Signature of Burial Officer		Signature of Cemetery Officer	

Printed and Published by the Registrar General, London

THE REGISTRAR GENERAL OF BIRTHS AND DEATHS  
GENERAL REGISTRATION OFFICE  
ST. MARTIN'S LANE, LONDON, W.C.2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND											
15979					15981						
1. PLACE OF DEATH a. COUNTY MONTGOMERY					2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE M.C. b. COUNTY						
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) SILVER STRING					c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) WASH D.C. 7616 13th NW						
c. LENGTH OF STAY IN 1b 2 YEARS					d. STREET ADDRESS 7616 B. St. NW						
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) Bella Vista Nursing Home					e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>						
3. NAME OF DECEASED (Type or print) First Middle Last SETSOKO TODA					4. DATE OF DEATH Month Day Year NOV 28 1966						
5. SEX F		6. COLOR OR RACE JAPANESE		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH 1896 - OCT 30		9. AGE (In years last birthday) 70 yrs.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) HOUSEWIFE		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) JAPAN		12. CITIZEN OF WHAT COUNTRY? JAPAN					
13. FATHER'S NAME (UNK) OGASAWARA					14. MOTHER'S MAIDEN NAME TEIKO (UNK)						
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) NO					16. SOCIAL SECURITY NO. NONE		17. INFORMANT HOSPITAL CHART				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypostatic pneumonia 334X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) DUE TO										INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cerebral & generalized arterio sclerosis										19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> DR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>			
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)								
21. I certify that (I) (this hospital) attended the deceased from 1965, to NOV 28, 1966 that (I) (we) last saw the deceased alive on NOV 25 19 66 and that death occurred at 6:25 M, from the causes and on the date stated above.											
22a. SIGNATURE Richard Kaufman					M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED NOV 28, 1966				
22c. PHYSICIAN'S NAME (Type) RICHARD KAUFMAN MD					22d. ADDRESS 1712 EYE ST NW WASH DC						
23a. BURIAL, CREMATION, REMOVAL (Specify) CREMATION			23b. DATE THEREOF 5 DEC 1966		23c. NAME OF CEMETERY OR CREMATORY LEE CREMATORY		23d. LOCATION (City, town or county) (State) WASHINGTON D.C.				
24. FUNERAL DIRECTOR Rinaldi Funeral Home 7400 Georgia Ave. NW					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
					DATE DEC 2 1966		j Charles Judge				

18851

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15980

CERTIFICATE OF DEATH

15982

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>			c. LENGTH OF STAY IN 1b <b>4 mo, 21da.</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WASHINGTON</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL HALL SANITARIUM</b>				d. STREET ADDRESS <b>N.W. 2401 CALVERT STREET</b>			
3. NAME OF DECEASED (Type or print) First <b>GERALDINE</b> Middle <b>C.</b> Last <b>TOOMEY</b>				4. DATE OF DEATH Month <b>11-</b> Day <b>1-</b> Year <b>19 66</b>			
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-22-82</b>		9. AGE (In years last birthday) <b>84</b> yrs.	10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RETIRED</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>WASHINGTON, D. C.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>JAMES TOOMEY</b>				14. MOTHER'S MAIDEN NAME <b>EILEEN C. MURRAY</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <b>JOHN J. TOOMEY 4215 DONNEL LANE</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>443x Acute Heart + Stopping</b> DUE TO (b) <b>Arteriosclerotic Hypertensive</b> DUE TO (c) <b>Heart Disease</b>						INTERVAL BETWEEN ONSET AND DEATH <b>1 min</b> <b>20 yrs.</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>April</b> , 19 <b>65</b> , to <b>11-1</b> , 19 <b>66</b> that (I) (we) last saw the deceased alive on <b>10/27</b> , 19 <b>66</b> , and that death occurred at <b>11:40 A.M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>W. Fleet Lockett</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>11-1-66</b>	
22c. PHYSICIAN'S NAME (Type) <b>W. FLEET LUCKETT</b>				22d. ADDRESS <b>5000 RENO ROAD, N.W. WASH. D.C.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE THEREOF <b>11-3-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>MT OLIVET CEMETERY</b>		23d. LOCATION (City or Town) (County) (State) <b>WASHINGTON, D. C.</b>	
24. FUNERAL DIRECTOR <b>FRANCIS J. COLEMAN 3821 14TH N.W. WASH. D.C.</b>				25a. REC'D BY REGISTRAR <b>NOV 4 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

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MINUTE OF DEATH

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15981

## CERTIFICATE OF DEATH

15983

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Garrett Park</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>10801 Montrose Ave.</b>		d. STREET ADDRESS <b>10801 Montrose Ave.</b>	
3. NAME OF DECEASED (Type or print) <b>HARRY V. TRAUB</b>		4. DATE OF DEATH Month <b>November</b> Day <b>10</b> Year <b>1966</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>17 Jan. 1901</b>
9. AGE (In years last birthday) <b>65</b> yrs.		IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Ret-Mechanic</b>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <b>W. Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>John Traub</b>		14. MOTHER'S MAIDEN NAME <b>Etta Jackson</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>yes</b>		16. SOCIAL SECURITY NO. <b>718-14-9132</b>	
17. INFORMANT <b>Mrs Maude L. Traub-Item# 2</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>3561 Amyotrophic Lateral Sclerosis</b> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (c) _____ DUE TO (c) _____		INTERVAL BETWEEN ONSET AND DEATH <b>6 Mos</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. _____ p.m. <b>19</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>OCT</b> , 19 <b>65</b> , to <b>11/10</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/10</b> , 19 <b>66</b> , and that death occurred at <b>9 AM</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>Raymond T. Benack</b> M.D.		22b. DATE SIGNED <b>11/10/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>RAYMOND T. BENACK MD</b>		22d. ADDRESS <b>4115 Colie Drive Wheaton MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11/14/66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>	23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Tyson Heeler Funeral Home-1331 Rockville Pike Rockville, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 14 1966</b>	
		25b. REGISTRAR'S SIGNATURE <b>J Charles Judge</b>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND 15982 CERTIFICATE OF DEATH 15984															
1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> c. LENGTH OF STAY IN 1b <b>3 yrs</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Asbury Methodist Home for the Aged, Inc.</b>					2. USUAL RESIDENCE (Where deceased lived, If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Gaithersburg</b> d. STREET ADDRESS <b>4138 Slater Avenue 36</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>										
3. NAME OF DECEASED (Type or print) First <b>Viola</b> Middle <b>Durham</b> Last <b>Tredway</b>					4. DATE OF DEATH Month <b>November</b> Day <b>8</b> Year <b>1966</b>										
5. SEX <b>F</b>		6. COLOR OR RACE <b>W</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>March 22, 1879</b>		9. AGE (In years last birthday) <b>87</b> yrs.		IF UNDER 1 YEAR Months <b>0</b> Days <b>0</b> Hours <b>0</b> Min. <b>0</b>		IF UNDER 24 HRS. Hours <b>0</b> Min. <b>0</b>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>housewife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>housewife</b>				11. BIRTHPLACE (County & State, or foreign country) <b>Harford County, Maryland</b>				12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>			
13. FATHER'S NAME <b>Abraham Durham</b>						14. MOTHER'S MAIDEN NAME <b>Louisa Whiteforth</b>									
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>				16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT <b>Asbury Methodist Home for the Aged, Md.</b>						Address <b>Gaithersburg</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Septicemia (Gram Neg.)</b> 5721 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last, <b>Peritonitis (ruptured)</b> DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										INTERVAL BETWEEN ONSET AND DEATH <b>2 days</b> <b>32 days</b>					
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>															
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that (I) (this hospital) attended the deceased from <b>4/1/63</b> , 19 <b>63</b> , to <b>11/8/66</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>11/8/66</b> , 19 <b>66</b> , and that death occurred <b>11/8/66</b> M, from the causes and on the date stated above.															
22a. SIGNATURE <b>Henry C. Scruggs, M.D.</b>										22b. DATE SIGNED <b>11/8/66</b>					
22c. PHYSICIAN'S NAME (Type) <b>Henry Scruggs, M. D.</b>										22d. ADDRESS <b>5413 Cedar Lane Bethesda Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-11-1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Watters Mem. Meth. Cemetery</b>				23d. LOCATION (City, town or county) (State) <b>Coopertown Harford Md.</b>							
24. FUNERAL DIRECTOR <b>Lassahn Funeral Home 2401 Belair Road</b>										25a. REC'D BY REGISTRAR <b>NOV 14 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. They please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
**CERTIFICATE OF DEATH**

15983

15985

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MASS.</b> b. COUNTY <b>—</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>KENSINGTON</b>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>BOSTON</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>CARROLL HALL SANITARIUM</b>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <b>EUGENIE</b> Middle <b>NMI</b> Last <b>VERGNES</b>			4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>24</b> Year <b>1966</b>		
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>JULY 2, 1882</b>	9. AGE (In years last birthday) <b>84</b> yrs.	IF UNDER 1 YEAR Months <b>—</b> Days <b>—</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>RET. TEACHER</b>			10b. KIND OF BUSINESS OR INDUSTRY <b>SCHOOLS</b>		11. BIRTHPLACE (County & State, or foreign country) <b>FRANCE</b>
13. FATHER'S NAME <b>EUGENE VERGNES</b>			12. CITIZEN OF WHAT COUNTRY? <b>FRANCE</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>			16. SOCIAL SECURITY NO. <b>071-26-4572</b>		
17. INFORMANT <b>MRS. K.S. BARREY, WASHINGTON, D.C.</b>			Address <b>WASHINGTON, D.C.</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>ARTERIOSCLEROTIC HEART DISEASE</b> 444X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>ESSENTIAL HYPERTENSION</b> DUE TO (c) <b>GENERALIZED ARTERIOSCLEROSIS</b>					INTERVAL BETWEEN ONSET AND DEATH <b>—</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>PARKINSONS SYNDROME</b>					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m. <b>—</b>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that (I) (this hospital) attended the deceased from <b>SEPT. 12, 1966</b> , to <b>NOV. 24, 1966</b> , that (I) (we) last saw the deceased alive on <b>NOV. 24, 1966</b> , and that death occurred at <b>5:15 P.M.</b> , from the causes and on the date stated above.					
22a. SIGNATURE <b>Henry M. Lowden</b>			22b. DATE SIGNED <b>NOV. 24 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>HENRY M. LOWDEN</b>			22d. ADDRESS <b>3206 NORWAY DR. CHEVY CHASE, MD</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE THEREOF <b>11-28-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>FOREST HILLS</b>	23d. LOCATION (City, town or county) (State) <b>SAMACIA PLAIN, MASS.</b>		
24. FUNERAL DIRECTOR <b>JOSEPH GAWLER'S SONS, WASH., D.C.</b>			25a. REC'D BY REGISTRAR <b>NOV 29 1966</b>		
			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

FOR STATE HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

15984

15986

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u> 15.1			
c. LENGTH OF STAY IN 1b <u>ROA.</u>				d. STREET ADDRESS <u>8220 Seven Locks Road</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>8220 Seven Locks Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Suzie Ware</u>				4. DATE OF DEATH <u>11 20 19 66</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Dec 4, 1904</u>	
9. AGE (In years last birthday) <u>61</u> yrs.		10. IF UNDER 1 YEAR Months Days		11. IF UNDER 24 HRS. Hours Min.		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life (even if retired)) <u>Domestic</u>				10b. KIND OF BUSINESS OR INDUSTRY			
13. FATHER'S NAME <u>Jim Keels</u>				14. MOTHER'S MAIDEN NAME <u>Maggie Cobb</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No.</u>				16. SOCIAL SECURITY NO.			
17. INFORMANT <u>McAllan Ware Seven Locks Road</u>				Address <u>8100</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Myocardial Infarction - Acute - 420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH <u>27 hr.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
22. ACTUAL SIGNATURE <u>John S. Ball</u> M.D.				22. DATE SIGNED <u>12/11/66</u>			
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> Address (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>12/4/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park Cem.</u>		23d. LOCATION (City or Town) (County) (State) <u>Rockville, Montg. Md.</u>	
24. FUNERAL DIRECTOR <u>Robert L. Snowden</u> ADDRESS <u>Rockville, Md.</u>				25a. REC'D BY REGISTRAR <u>DEC 7 1966</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15985

CERTIFICATE OF DEATH

15987

1. PLACE OF DEATH a. COUNTY <b>MONTGOMERY</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>MONTGOMERY</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>OLNEY</b>		c. LENGTH OF STAY IN 1b <b>3 DAYS</b>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>WOODBINE</b>		d. STREET ADDRESS <b>ROUTE 2</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>MONTGOMERY GENERAL HOSPITAL</b>		e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>EFFIE ALDER WARFIELD</b>		4. DATE OF DEATH Month <b>NOVEMBER</b> Day <b>2</b> Year <b>1966</b>	
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>9/17/87</b>
9. AGE (In years lost birthday) <b>79</b> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>UNEMPLOYED</b>	
11. BIRTHPLACE (County & State, or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>ROBERT WARFIELD</b>		14. MOTHER'S MAIDEN NAME <b>ROSE HILTON</b>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO. <b>220-54-0335</b>	
17. INFORMANT <b>HOSPITAL RECORDS</b>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), or (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>4221</b> DUE TO <b>Arteriosclerotic cardiovascular disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <b>Pulmonary edema</b> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <b>10 years - 14 months</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o.m. <b>19</b> p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>8/15</b> , 19 <b>55</b> , to <b>11/2</b> , 19 <b>66</b> , that (I) <b>(H)</b> last saw the deceased alive on <b>11/1</b> , 19 <b>66</b> , and that death occurred at <b>M</b> , from causes and on the date stated above.			
22a. SIGNATURE <b>James P. Kerr</b>		22b. DATE SIGNED <b>11/2/66</b>	
22c. PHYSICIAN'S NAME (Type) <b>JAMES P. KERR, M.D.</b>		22d. ADDRESS <b>DAMASCUS, MARYLAND</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE THEREOF <b>11-4-66</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Lebanon</b>	23d. LOCATION (City or Town) (County) (State) <b>Damascus, Md.</b>
24. FUNERAL DIRECTOR <b>Francis H. Barber</b>		25a. REC'D BY REGISTRAR DATE <b>NOV 9 1966</b>	
ADDRESS <b>Laytons ville, Md.</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

15087

CERTIFICATE OF DEATH

15087

15087

H. L. Latham

11-1-66

15087

To wit: H. L. Latham, of

1  
TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15986

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
CERTIFICATE OF DEATH

15988

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b> c. LENGTH OF STAY IN 1b <b>5 Days</b> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Maryland</b>			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>Washington</b> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Washington</b> d. STREET ADDRESS <b>1030-47th Street, N.W.</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <b>Annie Granette Washington</b>			4. DATE OF DEATH Month Day Year <b>November 25 19 66</b>		
5. SEX <b>Female</b>		6. COLOR OR RACE <b>Negro</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	
8. DATE OF BIRTH <b>1 May 1935</b>		9. AGE (In years last birthday) <b>31</b> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Domestic</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>---</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>			13. FATHER'S NAME <b>James Washington</b>		
14. MOTHER'S MAIDEN NAME <b>Nannie Turner</b>			15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		
16. SOCIAL SECURITY NO. <b>223-58-0706</b>			17. INFORMANT <b>The Medical Records, The Clinical Center, Bethesda 14, Maryland</b>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral Edema</b> 7542 DUE TO arteriosus Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Ventricular Septal Defect; patent ductus/</b> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of Item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		(County)		(State)	
21. I certify that <del>he</del> (this hospital) attended the deceased from <b>20 November, 1966</b> , to <b>25 November 1966</b> , that <del>we</del> last saw the deceased alive on <b>25 November 19 66</b> , and that death occurred at <b>6:00, a.m.</b> from the causes and on the date stated above.					
22a. SIGNATURE <i>Hamner Hannah</i>			22b. DATE SIGNED <b>25 Nov. 1966</b>		
22c. PHYSICIAN'S NAME (Type) <b>Hamner Hannah, 111, MD.</b>			22d. ADDRESS <b>The Clinical Center, National Institutes of Health, Bethesda 14, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>Dec. 3 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Beulah Church</b>	
23d. LOCATION (City, town or county)		(State)		25a. REC'D BY REGISTRAR <b>Nov 29 1966</b>	
25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>					

15384

15384

Director of Education

Director of Education

Washington, D.C.

Washington, D.C.

The Director of Education, Department of the Interior, Bureau of Indian Affairs, Washington, D.C.

November 15, 1954

Dear Sir:

Re:

1

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.

Very truly yours,

USA

Director

Director

Very truly yours,

Very truly yours,

Enclosed for you are two copies of a letterhead memorandum dated and captioned as above.

1

USA

Director

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,

Very truly yours,



15987

CERTIFICATE OF DEATH

15989

1. PLACE OF DEATH a. COUNTY <u>MONTGOMERY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>District of Columbia</u> b. COUNTY <u>Washington</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>KENSINGTON</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Washington 16, D.C.</u>			
c. LENGTH OF STAY IN 1b <u>6 YRS-3 month</u>				d. STREET ADDRESS <u>5103 Cherry Chase Pkwy.</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>KENSINGTON GARDENS SANITARIUM</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>STELLA H. WATERS</u>				4. DATE OF DEATH Month <u>Nov.</u> Day <u>5</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/16/76</u>	9. AGE (In years last birthday) <u>89</u> yrs.	10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>U.S. Govt. Ret.</u>		11. BIRTHPLACE (County & State, or foreign country) <u>TENNESSEE</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Shelah WATERS</u>				14. MOTHER'S MAIDEN NAME <u>Elizabeth McGARR</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Mamie M. Waters</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arteriosclerotic cerebral</u> DUE TO <u>vascular disease</u> (b) <u>generalized arteriosclerosis</u> DUE TO <u>generalized arteriosclerosis</u> (c) <u>generalized arteriosclerosis</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1960</u> <u>20 yrs</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u>19</u> p.m.				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>4/1</u>	
20f. (City or town) (County) (State) <u>11/5</u> <u>1966</u> <u>Washington 16 D.C.</u>				21. I certify that (I) (this hospital) attended the deceased from <u>4/1</u> , 19 <u>64</u> , to <u>11/5</u> , 19 <u>66</u> that (I) (we) last saw the deceased alive on <u>11/5</u> 19 <u>66</u> , and that death occurred at <u>1:30 A.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>H.F. Kreuzburg</u>				22b. DATE SIGNED <u>11/5/66</u>		22c. PHYSICIAN'S NAME (Type) <u>H.F. Kreuzburg</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>				23b. DATE THEREOF <u>11/8/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Mt. Olivet Cemetery</u>	
23d. LOCATION (City or Town) (County) (State) <u>Washington, D.C.</u>				24. FUNERAL DIRECTOR <u>Tyson Wheeler Funeral Home</u>		25a. REC'D BY REGISTRAR <u>NOV 9 1966</u>	
25b. REGISTRAR'S SIGNATURE <u>Johnes Judge</u>				25c. REGISTRAR'S SIGNATURE <u>Johnes Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15382

CERTIFICATE OF DEATH

15381

2

STATE OF NEW YORK  
DEPARTMENT OF HEALTH  
BUREAU OF VITAL RECORDS  
ALBANY, N. Y.

# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## CERTIFICATE OF DEATH

15988

15990

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Takoma Park</u>		c. LENGTH OF STAY IN lb. <u>20 days</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u> 15-1			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Washington Sanitarium + Hospital</u>				d. STREET ADDRESS <u>9611 Armistead rd.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Ida</u> Middle <u>Mary</u> Last <u>Weber</u>				4. DATE OF DEATH Month <u>11</u> Day <u>23</u> Year <u>1966</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-5-1915</u> 57 yrs.		9. AGE (In years last birthday)	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HSWF</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>own home</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Italy Jamico V.</u>		12. COUNTRY OF WHAT CITIZEN? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Michael Cusciano</u>				14. MOTHER'S MAIDEN NAME <u>Brunetta Masciandaro</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u> <u>None</u>		16. SOCIAL SECURITY NO. <u>578-24-9448</u> <u>Yes</u>		17. INFORMANT <u>Louis M. Weber</u> Address <u>Same as # 2</u> <u>Charles Washington Sanitarium + Hospital</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cardiac, Renal and respiratory</u> <u>170X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>failure due to extensive metastases</u> (c) <u>from adenocarcinoma of right breast</u>							INTERVAL BETWEEN ONSET AND DEATH <u>4 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (I) (this hospital) attended the deceased from <u>Dec</u> , 1961 to <u>Nov 23</u> , 1966 that (I) (we) last saw the deceased alive on <u>Nov 23</u> , 1966, and that death occurred at <u>1203</u> M, from causes and on the date stated above.							
22a. SIGNATURE <u>W. W. Eastman</u>				M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <u>Nov 23, 1966</u>	
22c. PHYSICIAN'S NAME (Type) <u>W. W. EASTMAN M.D.</u>				22d. ADDRESS <u>1200 Prospect L.K.P. Md</u>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Nov. 24, 1966</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Crematory</u>		23d. LOCATION (City or Town) (County) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>Glen Carter</u> <u>Warner E. Humphrey, Inc.</u>				ADDRESS <u>8434 Georgia Ave.</u> <u>Silver Spring, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>NOV 28 1966</u>	
				25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1126

VR A15 (4)  
20 M 1/66

**TO FUNERAL DIRECTOR:** After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please: remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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15989

MARYLAND STATE DEPARTMENT OF HEALTH  
 RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE  
 Items 7, 11 Film G385 2/15/67 mm  
 CERTIFICATE OF DEATH

15991

1. PLACE OF DEATH a. COUNTY MONTGOMERY		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE Maryland	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring		b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
c. LENGTH OF STAY IN 1b 2 weeks		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Silver Spring	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Holy Cross of Silver Spring		d. STREET ADDRESS 9920 Georgia Ave.	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First Middle Last William A. M. Welles.		4. DATE OF DEATH Month Day Year November 8, 1966	
5. SEX M.	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 5/30/01
9. AGE (In years lost birthday) 65 yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Engineer		10b. KIND OF BUSINESS OR INDUSTRY VITRO LABS.	
11. BIRTHPLACE (County & State, or foreign country) New York		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Not Known		14. MOTHER'S MAIDEN NAME Not Known	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) No		16. SOCIAL SECURITY NO. 579-14-8651	
17. INFORMANT DONALD H. WELLES		9326 Cypresswood Dr. JACKSONVILLE FLA.	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>CEREBROVASCULAR ACCIDENT</u> 332K DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u>BASILAR ARTERY THROMBOSIS</u> DUE TO (c) <u>CEREBROVASCULAR ATHEROSCLEROSIS</u> 334		INTERVAL BETWEEN ONSET AND DEATH 16 DAYS 16 DAYS UNKNOWN	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o) <u>ATHEROSCLEROTIC HEART DISEASE</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>SEPT 30, 1965</u> , to <u>NOV 8, 1966</u> , that (I) (we) last saw the deceased alive on <u>NOV 8, 1966</u> , and that death occurred at <u>2:54 A.M.</u> from causes and on the date stated above			
22a. SIGNATURE Edward G. Beeman		22b. DATE SIGNED NOV 8, 1966	
22c. PHYSICIAN'S NAME (Type) EDWARD A. BEEMAN		22d. ADDRESS 1015 SPRING ST. SILVER SPRING, MD.	
23a. BURIAL CREMATION, REMOVAL (Specify) Burial		23b. DATE THEREOF 11-10-66	
23c. NAME OF CEMETERY OR CREMATORY FAIRFAX MEM. GARDENS		23d. LOCATION (City or Town) (County) (State) FAIRFAX COUNTY VA.	
24. FUNERAL DIRECTOR J. M. Jackson		25a. REC'D BY REGISTRAR DATE NOV 14 1966	
25b. REGISTRAR'S SIGNATURE Charles Judge			

10001

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RECEIVED  
U.S. DEPARTMENT OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C. 20535  
JAN 10 1964



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15990 CERTIFICATE OF DEATH 15992

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u>		c. LENGTH OF STAY IN 1b <u>20 7/16 yrs.</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>16301 New Hampshire Avenue</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Spencerville</u> <u>15.1</u>	
3. NAME OF DECEASED (Type or print) First <u>Isabel</u> Middle <u>Stabler</u> Last <u>WESLEY</u>		d. STREET ADDRESS <u>16301 New Hampshire Ave.</u>	
4. DATE OF DEATH Month <u>November</u> Day <u>25</u> Year <u>1966</u>		8. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. AGE (In years last birthday) <u>66</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>Washington, D. C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Albert Stabler</u>		14. MOTHER'S MAIDEN NAME <u>Lena Janney</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes give war or dates of service) <u>None</u>		16. SOCIAL SECURITY NO. <u>yes</u>	
17. INFORMANT <u>Mr. L. Stuart Wesley</u>		Address <u>5503 Montltrie Rd. Springfield, Va.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u> 170X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) <u>Adenocarcinoma, Breast, widespread metastases</u> DUE TO (c) <u>4 yrs.</u>			INTERVAL BETWEEN ONSET AND DEATH <u>5 DAYS</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>1964</u> , 19 <u>  </u> to <u>11/25/66</u> , 19 <u>  </u> , that (I) (we) last saw the deceased alive on <u>11/24/66</u> 19 <u>  </u> , and that death occurred at <u>12:01</u> A.M., from the causes and on the date stated above.			
22a. SIGNATURE <u>Henry C. Scruggs MD</u>		22b. DATE SIGNED <u>11/25/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>HENRY C. SCRUGGS MD</u>		22d. ADDRESS <u>5413 Cedar Lane Bethesda Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Cremation</u>		23b. DATE THEREOF <u>Nov. 28, 1966</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery</u>		23d. LOCATION (City, town or county) (State) <u>Prince Georges Co., Md.</u>	
24. FUNERAL DIRECTOR <u>John B. Thomas</u> <u>Warner E. Humphrey, Inc.</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		DATE <u>DEC 1 1966</u>	

1530

1530

*[Faint, illegible text and markings covering the page, possibly bleed-through from the reverse side. Some faint words like "1971" and "1530" are visible.]*

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15991

## CERTIFICATE OF DEATH

15993

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>D. C.</b> b. COUNTY <b>-</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington, D. C.</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Suburban</b>		d. STREET ADDRESS <b>2500 Wisconsin Ave., N. W.</b>	
3. NAME OF DECEASED (Type or print) First <b>CLARENCE</b> Middle <b>B.</b> Last <b>WHALEY</b>		4. DATE OF DEATH Month <b>November 8,</b> Day <b>19</b> Year <b>66</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11/4/1901</b>
9. AGE (In years last birthday) <b>65</b> yrs.		10. IF UNDER 1 YEAR Months <b>6</b> Days <b>14</b> Hours <b>20</b> Min.	
11. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Retired</b>		12. KIND OF BUSINESS OR INDUSTRY <b>Lawyer</b>	
13. BIRTHPLACE (County & State, or foreign country) <b>Washington, D. C.</b>		14. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
15. FATHER'S NAME <b>Frederick Whaley</b>		16. MOTHER'S MAIDEN NAME <b>Lucy B. Underwood</b>	
17. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		18. SOCIAL SECURITY NO. <b>579-60-6886</b>	
19. INFORMANT <b>Mrs. Lillian L. Helm</b>		Address <b>See Item #2.</b>	
19. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial infarction</b> <b>5271</b> DUE TO Relative coronary insufficiency (b) Pulmonary emphysema, severe (c)		INTERVAL BETWEEN ONSET AND DEATH <b>4 days</b> <b>1 year</b> <b>20 years</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Bronchopneumonia and polycythemia</b>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov 7</b> , 19 <b>66</b> , to <b>Nov 8</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Nov 7</b> , 19 <b>66</b> , and that death occurred at <b>3:40</b> A.M. from causes and on the date stated above.			
22a. SIGNATURE <b>Stewart Clapp</b>		22b. DATE SIGNED <b>NOV 8 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Stewart Clapp M.D.</b>		22d. ADDRESS <b>4740 Chevy Chase Dr. N.W.</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-12-1966</b>	
23c. NAME OF CEMETERY OR CREMATORY <b>Congressional Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>	
24. FUNERAL DIRECTOR <b>Joseph Hawley's Sons</b>		25a. REC'D BY REGISTRAR <b>Wash., D.C.</b>	
25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		DATE <b>NOV 14 1966</b>	

15551

STATE OF NEW YORK

15551

IN SENATE,  
January 15, 1914.  
REPORT  
OF THE  
COMMISSIONER OF THE  
LAND OFFICE,  
IN RESPONSE TO A  
RESOLUTION PASSED  
BY THE SENATE,  
JANUARY 14, 1913.  
ALBANY:  
J. B. LEECH, JR.,  
PRINTERS,  
1914.

## CERTIFICATE OF DEATH

Reg. Dist. No.

15994

15992

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Olney</u>		c. LENGTH OF STAY IN 1b <u>1 day</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Montgomery General Hospital</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Leola</u> Middle <u>Williams</u> Last <u>Williams</u>		4. DATE OF DEATH Month <u>November</u> Day <u>18</u> , Year <u>1966</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Negro</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>5/10/87</u>
9. AGE (In years last birthday) <u>79 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u> Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>  </u>	
11. BIRTHPLACE (State or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Reuben Hill</u>		14. MOTHER'S MAIDEN NAME <u>Carrie Blair</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>  </u>		16. SOCIAL SECURITY NO. <u>  </u>	
17. INFORMANT <u>Medical Records</u>		Address <u>Olney, Maryland</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>446X ANURIA* - UREMIA</u> DUE TO (b) <u>ARTERIOLAR NEPHROSCLEROSIS</u> DUE TO (c) <u>ARTERIO SCLEROSIS, GEN'L</u> INTERVAL BETWEEN ONSET AND DEATH <u>TERMINAL*</u> <u>YES</u> <u>YES</u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>OBSTRUCTION - JETUNED - PULM. EDEMA - ABSENT @ Kidney</u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>  </u>	
20c. TIME OF INJURY Month <u>  </u> Day <u>  </u> Year <u>1966</u> Hour <u>  </u> o. p. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>  </u>		20f. (City or town) (County) (State) <u>  </u>	
21. I certify that I attended the deceased from <u>11/16</u> , 19 <u>66</u> , to <u>11/18</u> , 19 <u>66</u> , that I last saw the deceased alive on <u>11/18/66</u> , 19 <u>  </u> , and that death occurred at <u>6:25 a</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>  </u> DATE SIGNED <u>11/19/66</u>			
ACTUAL SIGNATURE <u>Donald R. Lewis</u> M.D.		PHYSICIAN'S NAME (Type) <u>Donald R. Lewis, M.D.</u> Medical Center, Sandy Spring, Maryland	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>11/22/66</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Lincoln Park</u>		22d. LOCATION (City, town, or county) (State) <u>Rockville, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Immanuel Free Home</u>		ADDRESS <u>Rockville, Md.</u>	
24a. REC'D BY REGISTRAR <u>NOV 23 1966</u>		24b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be attached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.





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1

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15993

CERTIFICATE OF DEATH

15995

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>		c. LENGTH OF STAY IN 1b <u>15.1</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hospital</u>		d. STREET ADDRESS <u>1605 Bonifant St</u>	
3. NAME OF DECEASED (Type or print) <u>William H. Williams</u>		4. DATE OF DEATH <u>11 29 1966</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10-3-87</u>
9. AGE (In years last birthday) <u>79</u> yrs.		10. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DOCTOR (RETIRED)</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>UNKNOWN</u>	
11. BIRTHPLACE (County & State, or foreign country) <u>D.C.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>WILLIAM HENRY WILLIAMS</u>		14. MOTHER'S MAIDEN NAME <u>HELENA ROSENGARN</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>UNKNOWN</u>		16. SOCIAL SECURITY NO. <u>UNKNOWN</u>	
17. INFORMANT <u>W. D. Janni R. W. (chart.)</u>		Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1 coronary thrombosis</u> DUE TO (b) <u>stroke</u> DUE TO (c) <u>Generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Generalized arteriosclerosis</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>8/1/66</u> , 19 <u>66</u> , to <u>11/29/66</u> , 19 <u>66</u> , that (I) (we) last saw the deceased alive on <u>11/29/66</u> , 19 <u>66</u> , and that death occurred on <u>2P</u> M, from causes on and on the date stated above.			
22a. SIGNATURE <u>Patrick Jameson</u> M.D.		22b. DATE SIGNED <u>11/29/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>PATRICK JAMESON</u>		22d. ADDRESS <u>11718 Georgia Silver Spring Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>	23b. DATE THEREOF <u>12/3/1966</u>	23c. NAME OF CEMETERY OR CREMATORY <u>George Washington</u>	23d. LOCATION (City or Town) (County) (State) <u>Riggs Extd Hospital, Md</u>
24. FUNERAL DIRECTOR <u>W.W. CHAMBERS, INC SILVER SPRING, MD</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
25b. REGISTRAR'S SIGNATURE		DATE <u>DEC 6 1966</u>	

15005

UNITED STATES OF AMERICA

15005

RECEIVED  
JAN 10 1964  
U.S. DEPT. OF JUSTICE  
FEDERAL BUREAU OF INVESTIGATION  
WASHINGTON, D.C.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15994

CERTIFICATE OF DEATH

15996

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Olney</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Montgomery General Hospital</b>				d. STREET ADDRESS <b>Rt. 3</b>			
3. NAME OF DECEASED (Type or print) <b>George Washington Wilt</b>				4. DATE OF DEATH Month <b>Nov.</b> Day <b>15</b> Year <b>19 66</b>			
5. SEX <b>Male</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>2-19-24</b>	9. AGE (In years last birthday) yrs. <b>42</b>	10. IF UNDER 1 YEAR Months Days Hours Min.		11. IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Surveyor</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Virginia</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <b>Theresa Wilt</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16. SOCIAL SECURITY NO.		17. INFORMANT <b>Montgomery Gen. Hospital</b> Address <b>Olney, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cerebral embolism with rt. hemiplegia</b> DUE TO (b) <b>Myocardial infarction with mural thrombus</b> DUE TO (c) <b>ASCVD</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.							INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b> <b>10 days</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>11-5-66</b> to <b>11-15-66</b> , that (I) (we) last saw the deceased alive on <b>11-14</b> 19 <b>66</b> , and that death occurred at <b>2:30am</b> , from causes and on the date stated above.							
22a. SIGNATURE <b>Frederick Moomau</b> M.D.				ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>Nov. 15, '66</b>	
22c. PHYSICIAN'S NAME (Type) <b>Dr. Frederick Moomau</b>				22d. ADDRESS <b>Medical Center, Sandy Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE THEREOF <b>11-18-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Forest Oak</b>		23d. LOCATION (City or Town) (County) (State) <b>Gaithersburg, Montg. Md</b>	
24. FUNERAL DIRECTOR <b>Ernest C. Gartner</b> ADDRESS <b>2nd</b>				25a. REC'D BY REGISTRAR DATE <b>NOV 18 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

15385

15385

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. at Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

70

2

99-1

VR A15 (4)  
20 M 1/66

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15995

CERTIFICATE OF DEATH

15997

1. PLACE OF DEATH o. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) o. STATE <u>md.</u> b. COUNTY <u>Mont.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Rockville</u> 15-1	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban</u>		d. STREET ADDRESS <u>302 Monroe St.</u>	
3. NAME OF DECEASED (Type or print) <u>Chara</u> First <u>WIRE</u> Middle Last		4. DATE OF DEATH <u>11-26</u> 19 <u>66</u> Month Day Year	
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>1-21-1878</u> 88 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Homemaker</u>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>C. Hall</u>		14. MOTHER'S MAIDEN NAME <u>Mary R. Pyles</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>215-38-3633</u>	
17. INFORMANT <u>Paul F. Wire - son- 11 Wall St;</u> Address <u>Rockville, Md.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Infarction</u> DUE TO <u>332X</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Cerebral Thrombosis</u> DUE TO (c) <u>Cerebral Arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u> <u>4 hrs</u> <u>15 yrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <u>Ca. of colon - Myocardial Infarction</u>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 1B.)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. 19 p.m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>11/21/66</u> to <u>11/26/66</u> that (I) (we) last saw the deceased alive on <u>11/26/66</u> and that death occurred at <u>12:00 P.M.</u> from causes and on the date stated above.			
22a. SIGNATURE <u>Stephen Jones</u>		22b. DATE SIGNED <u>11/26/66</u>	
22c. PHYSICIAN'S NAME (Type) <u>Stephen Jones</u>		22d. ADDRESS <u>Rockville, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11/29/66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Rockville</u>	23d. LOCATION (City or Town) (County) (State) <u>Rockville Md.</u>
24. FUNERAL DIRECTOR <u>Wheeler Funeral Home</u> ADDRESS <u>1351 Rockville Pike Rockville, Md.</u>		25a. REC'D BY REGISTRAR DATE <u>DEC 1 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

15333

(EQUITY OF DEED)

15333

15333



15996

CERTIFICATE OF DEATH

15998

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>Montgomery</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring</u>			c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Silver Spring 15-1</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Holy Cross Hosp.</u>				d. STREET ADDRESS <u>733 Sligo Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>MINNIE B WOOD</u>				4. DATE OF DEATH Month <u>NOV</u> Day <u>15</u> Year <u>1966</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8-23-90</u>		9. AGE (In years last birthday) yrs. <u>76</u>	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Clerk</u>		11. BIRTHPLACE (County & State, or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Stephen I. Boteler</u>				14. MOTHER'S MAIDEN NAME <u>Susan A. Peters</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <u>No</u>		16. SOCIAL SECURITY NO. <u>704-14-1259</u>		17. INFORMANT <u>Nan B. Yancey-10014 Brunett Ave, S.S.</u>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Ruptured aortic aneurysm</u> DUE TO (b) <u>Arteriosclerotic aortic aneurysm</u> DUE TO (c) <u>3+ yrs.</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							INTERVAL BETWEEN ONSET AND DEATH <u>30 hrs</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)		
21. I certify that (1) (this hospital) attended the deceased from <u>Nov. 15, 1966</u> , to <u>Nov 15, 1966</u> , that (1) we last saw the deceased alive on <u>Nov 15, 1966</u> , and that death occurred at <u>3:55 PM</u> , from causes and on the date stated above.							
22a. SIGNATURE <u>James R. Coleman MD.</u>				22b. DATE SIGNED		22c. PHYSICIAN'S NAME (Type) <u>JAMES R. COLEMAN</u>	
22d. ADDRESS <u>9241 COLUMBIA BLVD SILVER SPRING, MD.</u>				22e. M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		23b. DATE THEREOF <u>11/17/66</u>		23c. NAME OF CEMETERY OR CREMATORY <u>Fort Lincoln Cemetery Colmar Manor Maryland</u>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <u>J. Wm. Lees Sons</u>				25a. REC'D BY REGISTRAR <u>300 4th St. NE Washington, DC</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15936

15936

GENERAL OF DEPT.

NO.

NO.

NO.

NO.

NO.

NO.

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NO.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
20M 1/65

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND  
15999  
CERTIFICATE OF DEATH  
15999

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Montgomery</b>			
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Silver Spring</b>				c. LENGTH OF STAY IN 1b <b>15.1</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>1300 Magnolia Lane</b>				d. STREET ADDRESS <b>1300 Magnolia Lane</b>			
3. NAME OF DECEASED (Type or print) First <b>Joe</b> Middle <del>XXXXXX</del> Last <b>Wesley Woodward</b>				4. DATE OF DEATH Month <b>November</b> Day <b>28</b> Year <b>1966</b>			
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>April 9, 1920</b>	
9. AGE (In years last birthday) <b>46</b> yrs.		IF UNDER 1 YEAR Months <b>28</b> Days <b>19</b> Hours <b>66</b> Mln.		11. BIRTHPLACE (County & State, or foreign country) <b>County Somerset Pa.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Senior Custom Engr.</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>International Business Machines</b>			
13. FATHER'S NAME <b>E. M. Woodward</b>				14. MOTHER'S MAIDEN NAME <b>Fern Spangler</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>AW 11</b>		17. INFORMANT <b>Naomi S. Woodward</b>		Address <b>1300 Magnolia Lane Silver Spring, Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchiogenic carcinoma</b> <b>162.1</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>—</b> DUE TO (c) <b>—</b>							INTERVAL BETWEEN ONSET AND DEATH <b>2 months</b>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. <b>19</b> p.m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>1950</b> , 19 <b>to November 28, 1966</b> , that (I) (we) last saw the deceased alive on <b>November 24 1966</b> , and that death occurred at <b>5:30 PM</b> , from the causes and on the date stated above.							
22a. SIGNATURE <b>Bennet A. Porter, Jr., M.D.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>November 28, 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Bennet A. Porter, Jr., M.D.</b>				22d. ADDRESS <b>9301 Colesville Rd., Silver Spring, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>Dec. 1, 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Parklawn Cemetery</b>		23d. LOCATION (City, town or county) (State) <b>Rockville, Maryland</b>	
24. FUNERAL DIRECTOR <b>Clark E. Wison</b> <b>Warner E. Humphrey, Inc.</b>				ADDRESS <b>8434 Georgia Ave. Silver Spring, Md.</b>		25a. REC'D BY REGISTRAR <b>NOV 30 1966</b>	
				25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

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Dec. 1, 1930

Dec. 1, 1930

James E. ...  
Silas ...

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

15998

MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

16000

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b>		b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <b>Bethesda</b>		c. LENGTH OF STAY IN 1b <b>7 Days</b>		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Illinois</b>		b. COUNTY <b>Peoria</b>			
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <b>The Clinical Center, Bethesda 14, Maryland</b>						e. STREET ADDRESS <b>1914 West Garden Street</b>				f. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Richard Eugene Yocom</b>		First <b>Richard</b>		Middle <b>Eugene</b>		Last <b>Yocom</b>		4. DATE OF DEATH Month <b>November</b>		Day <b>29</b>	
5. SEX <b>Male</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>10 April 1945</b>		9. AGE (In years last birthday) <b>21</b> yrs.		IF UNDER 1 YEAR Months <b>21</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Drill Operator</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Construction</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Illinois</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>					
13. FATHER'S NAME <b>Wilbur E. Yocom</b>						14. MOTHER'S MAIDEN NAME <b>Betty Costley</b>					
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>Yes</b>		16. SOCIAL SECURITY NO. <b>1963 - 66</b>		17. INFORMANT <b>The Medical Records,</b>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Lymphosarcoma (Burkitt's type)</b> 200.1 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of Injury in Part I or Part II of Item 18.)									
20c. TIME OF INJURY Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) <b>Decatur, Illinois</b>		(County) <b>Illinois</b>		(State) <b>Illinois</b>	
21. I certify that (x) (this hospital) attended the deceased from <b>22 November 1966</b> , to <b>29 November 1966</b> , that (u) (we) last saw the deceased alive on <b>29 November 1966</b> , and that death occurred at <b>3:25 M.</b> from the causes and on the date stated above.											
22a. SIGNATURE <b>Martin H. Cohen, MD</b>						M.D. <b>Martin H. Cohen, MD.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>29 Nov. 1966</b>	
22c. PHYSICIAN'S NAME (Type) <b>Martin H. Cohen, MD.</b>						22d. ADDRESS <b>National Institutes of Health, The Clinical Center, Bethesda 14, Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial-transit 11-30-66</b>		23b. DATE THEREOF <b>11-30-66</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Fairlawn Cemetery</b>		23d. LOCATION (City, town or county) <b>Decatur, Illinois</b>		(State) <b>Illinois</b>			
24. FUNERAL DIRECTOR <b>Robert B. Humphrey</b>						ADDRESS <b>Bethesda, Maryland</b>		25a. REC'D BY REGISTRAR <b>DEC 5 1966</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	

332

• 1987 •



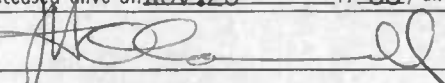
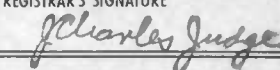
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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death.  
Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

15999

CERTIFICATE OF DEATH

16001

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>District of Columbia</b> b. COUNTY <b>h. COUNTY</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>		c. LENGTH OF STAY IN 1b <b>14 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Washington D.C.</b> <b>47-3</b>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>			d. STREET ADDRESS <b>4545 Connecticut Ave. Apt. 621</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>William</b> Middle <b>Southgate</b> Last <b>Zane</b>			4. DATE OF DEATH Month <b>November</b> Day <b>20</b> Year <b>1966</b>		
5. SEX <b>Male</b>	6. COLOR OR RACE <b>Cauc.</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	B. DATE OF BIRTH <b>June 9, 1884</b>		9. AGE (In years last birthday) <b>82 yrs.</b>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>USN</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (County & State, or foreign country) <b>Washington D.C.</b>	
13. FATHER'S NAME <b>Abram V. Zane</b>			14. MOTHER'S MAIDEN NAME <b>Grace Helen Southgate</b>		
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>Yes WW 1 and 11</b>		16. SOCIAL SECURITY NO. <b>163-28-7290</b>		17. INFORMANT Address <b>Emily Zane 4545 Conn. Ave., Washington DC</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Arteriosclerotic cardio vascular disease in failure</b> 4221 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <b>19</b>		20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input type="checkbox"/> at work at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 8</b> , 1966, to <b>Nov. 20</b> , 1966, that (I) (we) last saw the deceased alive on <b>Nov. 20</b> , 1966, and that death occurred at <b>940 p.m.</b> from causes and on the date stated above.					
22a. SIGNATURE 			ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22b. DATE SIGNED <b>22 NOV 1966</b>
22c. PHYSICIAN'S NAME (Type) <b>F. H. O'CONNELL, M.D.</b>			22d. ADDRESS <b>Naval Hospital, Bethesda, Md.</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE THEREOF <b>11-23-1966</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Arlington National</b>		23d. LOCATION (City or Town) (County) (State) <b>Arlington, Virginia</b>
24. FUNERAL DIRECTOR <b>Joseph Gawler &amp; Sons</b>			25a. REC'D BY REGISTRAR DATE <b>NOV 29 1966</b>		25b. REGISTRAR'S SIGNATURE 

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# MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

FOR STATE  
HEALTH DEPT.

16000

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

16002

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. The pages 1 and 2 with the State Department of Health or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Montgomery</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Montgomery</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Bethesda</u>		c. LENGTH OF STAY IN 1b <u>14 Min</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Suburban Hospital</u>		d. STREET ADDRESS <u>4542 Montgomery Ave.</u>	
3. NAME OF DECEASED (Type or print) <u>George Lawson Ziegler</u>		4. DATE OF DEATH <u>Nov 12 1966</u>	
5. SEX <u>male</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>3/21/27</u>
9. AGE (In years lost birthday) <u>39</u>		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Illustrator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>C.E.I.</u>	
11. BIRTHPLACE (State or foreign country) <u>California</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>George Gill Ziegler</u>		14. MOTHER'S MAIDEN NAME <u>Gladys A. Lawson</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <u>Yes. WW II Korea</u>		16. SOCIAL SECURITY NO. <u>368-32-3740</u>	
17. INFORMANT <u>Mother</u>		Address <u>Same as Item 2.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Hemothorax-Left-Massive-</u> DUE TO (b) <u>Gun-Shot-Wound-of-chest-</u> DUE TO (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>25 Min.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot-It-in-chest-22 Cal. Revolver-</u>	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			
ACTUAL SIGNATURE <u>John G. Ball</u>		22. DATE SIGNED <u>Nov. 12, 1966</u>	
EXAMINER'S NAME (Type) <u>JOHN G. BALL</u>		Address (Street, city, town, or county) <u>Bethesda, Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>11-15-66</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Arlington Natl Cem.</u>	23d. LOCATION (City or Town) (County) (State) <u>Arlington, Virginia</u>
24. FUNERAL DIRECTOR <u>ROBERT A. PUMPHREY, Bethesda, Maryland</u>		25a. REC'D BY REGISTRAR <u>NOV 17 1966</u>	
		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	

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MARYLAND STATE DEPARTMENT OF HEALTH  
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

16001

16003

1. PLACE OF DEATH a. COUNTY <b>Montgomery</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) a. STATE <b>Virginia</b> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Bethesda (rural)</b>			c. LENGTH OF STAY IN 1b <b>3 Days</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annadale</b>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>U.S. Naval Hospital</b>				d. STREET ADDRESS <b>7125 Dale Court</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Emilie Danculovic Zimmerman</b>				4. DATE OF DEATH Month <b>November</b> Day <b>18</b> Year <b>19 66</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Cauc</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>March 4, 1912</b>		9. AGE (In years lost birthday) <b>54</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Secretarial</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>U.S. Navy Dept.</b>		11. BIRTHPLACE (County & State, or foreign country) <b>Ohio</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>Mark Danculovic</b>				14. MOTHER'S MAIDEN NAME <b>Anna Rudman</b>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>273 09 08 06</b>		17. INFORMANT <b>7140 Conelly Blvd. Milan Dancull Bedford, Ohio 44014</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Subdural Hemotoma</b> <b>583x</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Severe Hepatic Decomposition</b> DUE TO (c)							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (o)							19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o.m. p.m. <b>19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <b>Nov. 16</b> , 19 <b>66</b> , to <b>Nov. 18</b> , 19 <b>66</b> , that (I) (we) last saw the deceased alive on <b>Nov. 18</b> , 19 <b>66</b> , and that death occurred at <b>130P M.</b> from causes and on the date stated above.							
22a. SIGNATURE <b>J.B. Emery MD</b>				22b. DATE SIGNED <b>Nov. 20, 1966</b>		22c. PHYSICIAN'S NAME (Type) <b>J.B. Emery MD</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Cremation</b>		23b. DATE THEREOF <b>21 Nov. 1966</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ft. Lincoln Crematory</b>		23d. LOCATION (City or Town) (County) (State) <b>Bladensburg, P.G. Co., Md.</b>	
24. FUNERAL DIRECTOR <b>W. W. Chambers Co., 1400 Chapin St., N. W./</b>				25. REC'D BY REGISTRAR <b>NOV 25 1966</b>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

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